

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

- A. The **State of Indiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**
Aged & Disabled Waiver
- C. **Waiver Number:**IN.0210
Original Base Waiver Number: IN.0210.90.R2
- D. **Amendment Number:**IN.0210.R05.03
- E. **Proposed Effective Date:** (mm/dd/yy)

06/30/17

Approved Effective Date: 06/30/17

Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to increase slots for waiver year 4 and waiver year 5 due to enrollment efforts by the operating agency as well as increased demand for enrollment into the A&D waiver.

Other changes are to increase the rate for the assisted living service projections within Appendix J effective 06/30/2017 for all three levels of this service to correlate with a rate increase to providers of this service. The increased rate for the assisted living service aligns with the Division of Aging's (DA) efforts to ensure compliance with the HCBS Settings final rule by March 2019, as outlined in Indiana's Statewide Transition Plan.

The DA is also removing the provider type "Home Health Agency" in Appendix C's Health Care Coordination service definition, in an effort to expand provider capacity for this service.

The operating agency is including the removal of "contracted entities" from multiple areas of the day-to-day functions of the waiver operation. Changes will also be mirrored in each table within the DA's performance measures that indicate a contractor's role. DA is removing contractor language from many of their day-to-day tasks and subsequent performance measures.

Below is an outline by section of all proposed changes within this amendment along with a brief summary of the change:

Amendment

3-A update Nature of Amendment sections

3-B Nature of Amendment

Main

2. Update slots

6-I Public Input- remove old language add new public comments for this amendment

7-A Update contact person

8. Authorization signature

Attachment #2- STP- remove outdated language and include a link to the CMS approved STP. Remove all prior STP language from past version.

Additional Needed information- remove language in this section specific to the Statewide Transition Plan.

Appendix A

A.2.a. remove MOU language

A.3. Contracted entities

- Update language from Utilization Management process.
- Remove "QA/QI" Improvement Contractor

A-4. Local/Regional non-governmental non-state entities

- Remove reference to Area Agency on Aging (AAA) as a contracted entity.

A-7- Waiver Admin. And Operation- uncheck all boxes for contractors related to operational duties.

A-6- Assessment Methods and Frequency-

A-7- Waiver Admin. And Operation- uncheck all boxes for contractors related to operational duties.

A-QIS-Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix B

Appendix B-3.a Participant Access

- Update year 4

B-QIS-Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix C

C-1-a Health Care Coordination- C-1 –

- Remove Home Health Agency as Provider type.

C-5.2 Home and Community Based Settings- add in new language

C-QIS- Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix D

D-QIS-Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix F

F.3.b & F.3.c- removed reference to DA's QA/QI contractor

Appendix G

G-QIS Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix H

H-QIS- Corrected QIS to show FSSA as single state agency. Removed reference to contractors for functions completed by the operating division.

Appendix I- Financial Accountability-

- Revise language to mirror current processes. Additional language added to describe process for determining rate increase.
- Change OMPP to FSSA
- Remove "at waiver provider meetings"
- Remove "Audit unit is responsible for annual review of services and billing performed by AAA with full reporting to OMPP"

and DA.”

Appendix J-

- Col. 1. Yr 4 and YR 5 update-
- J-2-a- WY 4 and WY 5
- J-2-b – update language on projections based on Milliman data.
- J-2.c.i- Derivation of Estimates. – update language.
- J-2.c.ii- Factor D’- update language
- J-2.c.iii- Factor G- update language
- J-2.c.iv. Factor G’- update language
- J-2-Cost Neutrality Demonstration- update chart.
- J-2-d.i – Estimate of Factor D- update charts for WY 4 and WY 5

3. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	Main 1, N
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	A-2.b, A-
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B-3.a, QI
<input checked="" type="checkbox"/> Appendix C – Participant Services	C-1.a, QI
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	QIS
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	F.3.b, F.3
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	QIS
<input checked="" type="checkbox"/> Appendix H	H.a.i
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	I-1, QIS
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-2.a, J-2.

- B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- ☐ Modify target group(s)
- ☐ Modify Medicaid eligibility
- ☐ Add/delete services
- ☐ Revise service specifications
- ☒ Revise provider qualifications
- ☒ Increase/decrease number of participants
- ☐ Revise cost neutrality demonstration
- ☐ Add participant-direction of services
- ☒ Other

Specify:

Increase rates for assisted living service by 5% for all three levels for WY 4 and waiver year 5.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Aged & Disabled Waiver
- C. **Type of Request:** amendment

Requested Approval Period:(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

☐ 3 years ☒ 5 years

Original Base Waiver Number: IN.0210

Waiver Number:IN.0210.R05.03

Draft ID: IN.004.05.03

- D. **Type of Waiver** (*select only one*):

Regular Waiver ▼

- E. **Proposed Effective Date of Waiver being Amended:** 07/01/13

Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

- F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

☐ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

☐ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

- G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☒ **Not applicable**

☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

- ☐ §1915(b)(1) (mandated enrollment to managed care)
- ☐ §1915(b)(2) (central broker)
- ☐ §1915(b)(3) (employ cost savings to furnish additional services)
- ☐ §1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PURPOSE: This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require nursing facility level of care. Through the use of the Aged & Disabled Waiver (A&D), The Family Social Service Administration (FSSA)'s Division of Aging (DA) seeks to increase availability and access to cost-effective aged and disabled waiver services.

GOALS: The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings such as their own homes, apartments, assisted living or adult family care.

OBJECTIVE: This waiver amendment anticipates serving the following unduplicated participants:

Year 1 (2013) 15,265
 Year 2 (2014) 16,081
 Year 3 (2015) 18,778
 Year 4 (2016) 21,153
 Year 5 (2017) 22,519

ORGANIZATIONAL STRUCTURE: The Family Social Services Administration (FSSA) is the Single State Medicaid Agency. The Indiana Division of Aging, a division under the FSSA, has been given the authority to administer the A&D Waiver. The Office of Medicaid Policy and Planning (OMPP) also a division under the FSSA has been given the administrative authority for the A&D waiver by the FSSA. The Indiana Division of Aging performs the daily operational tasks of the waiver.

SERVICE DELIVERY METHODS: A written service plan will be developed by qualified case managers for each participant

under this waiver. The service plan will describe the medical and other services (regardless of funding sources) to be furnished, their frequency, and the type of provider who will furnish each service. The service plan will be subject to the approval of the Division of Aging. Traditional service delivery methods are used.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ☒ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - ☐ **No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
 - ☒ **Not Applicable**
 - ☐ **No**
 - ☐ **Yes**
- C. **Statewidelessness.** Indicate whether the State requests a waiver of the statewidelessness requirements in §1902(a)(1) of the Act (*select one*):

☒ No

☐ Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party

(e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Due to limited character space within this section the State is including the remaining public comments under Main B. "Optional" for this amendment.

The State provided tribal notice to the Pokagon Tribe on the A&D amendment on 01/24/2017. The tribe offered no comments.

Public comment periods were announced and posted for 30 days on the FSSA's Division of Aging site at <http://www.in.gov/fssa/da/3476.htm>. The public comment period ran from 02/22/2017 through 03/24/2017, in advance of the submission of the waiver amendment. Non-electronic notice was provided via the Indiana Register. Paper copies of the amendment were available upon request from Area Agency on Aging offices. Comments were accepted electronically and/or via mail to respective electronic and USPS addresses.

The public comments were received from five individual sources. The comments and DA responses are outlined below:

Public Comment: One Commenter asked how do you ensure family choice in case management when the you [sic] have the local AAA doing the assessment for waiver services and they are also a case management entity? I have families express they were never told they can pick from outside the local AAA. How does the DA keep this from being a conflict of interest for the local AAA and how do they make sure the local AAA tells families of all their options.

DA response: AAAs are required to notify participants of all available case management providers; they must provide and acquire a signature on the pick list of available providers. This is reviewed in third party compliance reviews. DA appreciates your comment on this and will continue to monitor this situation closely.

Public Comment: One Commenter noted the AAA agencies are not equipped to handle the current volume of referrals for waiver determinations or increase in waiver slots. In some areas it takes months for a AAA case manager to complete the waiver application process. How is this being addressed? Furthermore what is the [sic] states plan to offer waiver to individuals who are already living in nursing homes but could be supported in the community? Nursing homes do not work well with this process.

DA response: In July of 2016, contracts were put in place with the Aging and Disability Resource Centers specifically for waiver intake functions. This had never existed before. Now specific monies are tied to these activities along with timeline expectations. Rates are reduced if timelines are not consistently met. Timelines have vastly improved since then and the DA believes ADRCs are building capacity but this is a situation DA will be continuing to watch as we move forward. Intake into HCBS options has to be quicker as we move forward.

DA participates in the Money Follows the Person program which provides services to move individuals from

institutional settings like nursing facility into home and community based settings. The DA has participated in this program since 2007. In 2016, the program was moved into the Aging and Disability Resource Centers.

Public Comment: One commenter noted that they are concerned that the Division of Aging's proposed Waiver Amendment threatens community integration by raising provider reimbursement rates only for assisted living placements. Stating, assisted living facilities may generally be considered settings that isolate their residents. They tend to be comprised of residential units solely for aged and/or disabled residents, to the exclusion of non-aged or disabled individuals. Some assisted living residents choose to enter these facilities to be near spouses or other loved ones residing in nearby nursing homes.

However, this proximity further supports the conclusion that assisted living facilities are not community-based. Centers for Medicare and Medicaid Services (CMS) has issued guidance on this topic.¹ It states that "[m]ultiple settings co-located and operationally related (i.e., operated and controlled by the same provider) that congregate a large number of people with disabilities together and provide shared programming and staff" are likely isolationist settings.² Indiana Disability Rights believes that increasing provider rates only in those settings that appear less community-based (i.e., assisted living facilities), the Division of Aging is promoting institutional bias.

DA response: DA agrees that it needs a more holistic review of all services and associated rates. DA will be undertaking a more complete review and looking more at comprehensive HCBS program design over the coming months. Additionally DA continues to work to address the challenges of the Settings Rule which calls for DA to work closely with assisted living providers to make changes in culture and practice to eliminate institutional [sic] characteristics and promote home and community based characteristics

Continued in Main B "Optional"

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone: **Ext:** ☐ TTY

Fax:

E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone: **Ext.:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:	<input type="text" value="402 W. Washington Street, W374"/>		
Address 2:	<input type="text"/>		
City:	<input type="text" value="Indianapolis"/>		
State:	Indiana		
Zip:	<input type="text" value="46204"/>		
Phone:	<input type="text" value="(317) 234-6143"/>	Ext: <input type="text"/>	<input type="checkbox"/> TTY
Fax:	<input type="text" value="(317) 232-7382"/>		
E-mail:	<input type="text" value="allison.taylor@fssa.in.gov"/>		

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Waiver Specific STP 05.09.2017

Tribal Notice was sent to the Pokagon Band of the Potawatomi Indians on December 19, 2016.
Indiana's Version 6 Statewide Transition Plan that included the A&D Waiver was open for public comment for 30 days, January 18, 2017 through February 17, 2017.

SECTION 1: SETTINGS INCLUDED IN THE A&D WAIVER TRANSITION PLAN
CHARTS DESCRIBED HERE CAN BE FOUND IN THE FULL VERSION OF THE STP AT
<http://www.in.gov/fssa/files/IN%20FSSA%20HCBS%20STP%20-%20V6%202017.03.30.pdf>

DA's analysis of settings where HCBS are provided has included:

- A crosswalk of Indiana Statute, Indiana Administrative Code (IAC), HCBS policy;
 - A self-survey of residential providers to assess operating practices, waiver participation levels and general adherence to HCBS rule principles;
 - Review of licensing rules and regulations, recently noted statute governing housing with services establishment (IC 12-10) still to be added to this analysis; and
 - Site surveys of all assisted living (AL), adult day service (ADS), and adult family care (AFC)
- The DA has determined the following waiver services can be presumed to fully comply with the regulatory requirements because they are individualized services provided in a residential setting that is not provider owned or controlled.
- Attendant Care: Assistance with activities of daily living
 - Case Management: Coordination of other waiver services, assuring freedom of choice and person-centered planning
 - Community Transition: Funds to purchase household needs for participants transitioning into their own home
 - Environmental Modification Assessment: Support to assure that home modifications are effective and efficient
 - Environmental Modifications: Home modifications to meet the participant's disability-related needs
 - Healthcare Coordination: Specialized medical support for participants with complex medical needs
 - Home Delivered Meals: Nutritional meals for participants who are unable to prepare them
 - Homemaker: Assistance with cleaning and routine household tasks
 - Nutritional Supplements: Liquid supplements such as "Boost" or "Ensure"
 - Personal Emergency Response System: Medical emergency alert systems for participants who spend time alone
 - Pest Control: Pest extermination services when health and safety is compromised
 - Respite Home Health Aide/ Respite Nursing: Respite services are services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations: in an individual's home or in the private home of the caregiver
 - Specialized Medical Equipment and Supplies: Adaptive equipment and supplies to help participants live more independently
 - Structured Family Caregiving: a living arrangement in which a participant lives in his or her private home or the private home of a principal caregiver who may be a related or unrelated individual who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant; support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving; only agencies may be structured family caregiving providers, with the structured family caregiving settings being approved, supervised, trained, and paid by the approved agency provider. This is not a provider owned or controlled setting as long as the caregiver is a related individual. DA will evaluate each situation individually to determine if the caregiver is an unrelated individual and if the participant resides in that caregiver's home. DA believes that few, if any, situations will prove to be provider owned or controlled but any that are will be assessed and remediated individually for compliance with the HCBS settings requirements. SFC will be included in regulatory language to cover any situations that do involve services in the home of an unrelated paid caregiver.
 - Transportation: Rides to assist participants in accessing community services, activities, and resources identified in the service plan
 - Vehicle Modifications: Modifications to vehicles to meet a participant's disability-related need

It is not the intention of CMS or DA of Indiana to take away any residential options, or to remove access to services and supports. The intent of the federal regulation and the Indiana transition plan is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. The DA has identified five services which are provided in provider owned settings:

- Adult Family Care: Residential services provided in a family-like setting; the AFC homes are approved to serve not more than four participants in a home-like setting in a residential community with a live-in caregiver.
- Adult Day Services: Activities provided in a group setting, outside the home
- Assisted Living: Residential services offering an increased level of support in a home or apartment-like setting.

SECTION 2: SYSTEMIC ASSESSMENT

The systemic assessment process included a thorough review of all applicable regulations in Indiana:

- 455 IAC 2 – DA administrative code currently covering all HCBS service providers and settings
- 455 IAC 3 – DA administrative code currently covering assisted living providers under DA Medicaid waivers
- 410 IAC 16.2 – Indiana State Department of Health (ISDH) residential care facility licensure rules (all Medicaid waiver assisted living providers are required to be licensed by ISDH)
- DA HCBS Provider Reference Module – provider module for Medicaid waiver programs

-IC 12-10-15 – Indiana code on housing with services establishments which requires a registration process and imposes other requirements on both licensed and unlicensed assisted living communities in Indiana

DA completed a preliminary review in 2015 followed by a more thorough legal review in early 2016. Following the completion of part of the site surveys, DA revisited the systemic assessment related to assisted living providers in particular. At that time, IC 12-10-15 was added to the review. Significant conflicts with 410 IAC 16.2 were noted. The extent of this conflict was highlighted as the site survey process was underway. final systemic review and crosswalk is now complete.

Systemic Assessment Crosswalk – summary of chart outlining compliance or lack thereof in current regulatory structure and proposed remediation activity.

SECTION 3: SITE SPECIFIC ASSESSMENT

The site specific assessment process generally consists of a provider self-survey, desk review of policy and procedure, and site assessments of all provider sites with current waiver participants to validate survey results.

The plan for site specific assessments started with provider self-surveys. DA distributed these to providers beginning in 2014 through spring of 2015. Participation was voluntary and return rates varied by service. More detail is provided in the service specific descriptions below. The intent of the self-survey process was to obtain a broad sense of where compliance issues existed in each type of setting. Between late 2015 and early 2016, DA utilized a contractor to request documentation from some service providers to conduct a broad policy and procedure review. Again, participation by providers was voluntary and the response rates varied. Once again the intention was to obtain a broad sense of the compliance issues and begin to validate the results of the self-survey process. Beginning in the spring of 2016, DA utilized a contractor to conduct site visits at 100% of its AFC, ADS, and AL sites with active waiver participants. In the spring of 2017, DA will check again for providers with active participants and complete site visits at that time if they did not have a 2016 site visit. For those that still do not have any waiver participants, they will be notified of the need to be re-certified given new requirements since their initial certification. Again, more details on this process are provided in each service specific section below.

Adult Family Care: Residential services provided in a family-like setting; the AFC homes are approved to serve not more than four participants in a home-like setting in a residential community with a live-in caregiver. While the HCBS waiver service definition reflects the requirements set forth in the final rule, it lacks the specificity of the rule. A self-survey of AFC providers was conducted as an initial assessment to identify areas in need of remediation. There are currently 39 enrolled AFC homes. There are 49 current waiver consumers in 24 AFC sites. The remaining 15 homes have no current waiver consumers residing in them. The response rate for the self-survey was 38%. The self-survey indicates that at least 73% of AFC homes will need to implement changes to address the standards:

- The individual can have visitors at any time;
- The individual controls his/her own schedule including access to food at any time;
- The setting is integrated in and supports full access to the greater community;
- The individual has choice of roommates; and
- Results also indicate that approximately 64% of providers use a lease or residency agreement, but it has not been determined if these are legally enforceable.

Surveys of 23 sites with active waiver participants were completed between February 2016 and June 2016. One additional site now has an active participant and will have a site survey completed in the spring of 2017. The site surveys confirmed the issues identified in the self-survey process. The most common areas of non-compliance include:

- Freedom and support to control own schedule and activities.
- Participants are able to participate in activities of their choice in the community alone.
- Ability to have visitors of choosing at any time
- Optimizes individual initiative, autonomy, and independence in making life choices.
- Medications maintained and distributed in a way that promotes individual control and privacy.
- Units have locking doors; with only appropriate staff having keys/privacy in sleeping or living unit
- Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible.

There may also be issues with lease agreements but additional document review will be necessary at each site.

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For AFC settings, all participants at the site will receive a short interview. The questions asked will be focused on the areas that required remediation. Interviews will be conducted by phone or in person by DA staff or contractor staff.

By January 2017, DA will develop a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and possible remediation strategies. Providers will receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-

compliance will be decertified by March 2019. Participants in those sites will be transitioned to a fully compliant site or transition off the waiver if this is their choice by December of 2018.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

There are no regulatory barriers to remediation. Language in regulations is largely silent or partially compliant in reference to AFC. Language will be enhanced or added to assure that all settings are required to be fully compliant with the HCBS settings requirements. Providers will be notified of the issues identified at each site. The DA will provide technical assistance to those providers who wish to remediate. For those providers that do not wish to remediate, the DA will work with case managers to provide person centered service planning and support to each individual to transition them into compliant HCBS settings as they may choose. At this time, the DA believes all providers will participate in remediation and no individual transitions will be needed. No AFC sites are co-located with nursing facilities.

-Assisted Living: Residential services offering an increased level of support in a home or apartment-like setting.

Assisted Living (AL) facilities are, by nature, somewhat isolating as they provide a full range of services within a facility. DA fully supports the concept of “aging in place” for elderly individuals who choose to receive services conveniently or in a residence which allows them to remain close to a loved one in a nearby nursing facility. The majority of Indiana’s assisted living sites are co-located with nursing facilities. The physical arrangement varies from being completely under the same roof to sharing common areas, sharing a parking lot, sharing a breezeway, etc.

There are currently 90 enrolled Assisted Living (AL) providers. There are 2,286 current waiver participants in those 90 assisted living sites. 40% of the enrolled AL providers have 10 or fewer waiver participants. The self-surveys completed by AL providers in the fall of 2014 indicated a high percentage of compliance with isolated incidents of remediation needed to achieve the following standards:

- The individual controls his/her own schedule including access to food at any time
- The individual has privacy in their unit including lockable doors
- The individual has choice of roommates
- The individual has a lease or other legally enforceable agreement providing similar protections
- The setting is integrated in and supports full access to the greater community
- The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- The individual can have visitors at any time

Documentation review of AL providers was completed in February 2016 with 56% of providers responding to the request for documentation, including policies, procedures, handbooks, staff training schedules, lease agreement templates, participant rights documents, etc. Documentation review and site surveys completed between February 2016 and June 2016 indicated more widespread lack of compliance in several key areas. These areas included:

- Freedom and support to control own schedule and activities.
- Participants are able to freely move about inside and outside the site.
- Participants are able to participate in activities of their choice in the community alone.
- Privacy in sleeping or living unit
- Staff and/or other participants knock on each other’s doors or ask for permission before entering participants’ rooms.
- Lockable bathrooms
- Ability to have visitors of choosing at any time – with appropriate privacy considerations.
- Access to food at any time – flexibility in meal times.
- Is the site free from gates, locked doors, or other barriers preventing individuals’ entrance to and exit from all areas of the setting?
- Optimizes individual initiative, autonomy, and independent in making life choices.
- Medications are maintained and distributed in a way that promotes individual control and privacy.
- Participants are able to dine alone or in a private area.
- Participants have easy access to have private communications with people outside the site by telephone, e-mail, and/or mail.

Units have locking doors; with only appropriate staff having keys.

In total, 84 Assisted Living locations were surveyed as part of the site assessments. Following the visits, it was determined that:

1. 30 Assisted Living sites are co-located with a nursing facility but they did not house a secure memory care.
2. 15 Assisted Living sites are both co-located and have a secure memory care.
3. 12 Assisted Living sites were not co-located but do have a secure memory care.
4. 24 sites were not co-located and did not have a secure memory care.
5. All 84 sites (plus 6 that only one or two consumers plan to stop participating and so were not surveyed) are licensed as residential care facilities. The six sites that were not surveyed will formally indicate their intention to withdraw in early 2017. Meanwhile they are not taking on any new participants.

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each

site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For AL settings, 10% of the site's participants, or 10 individuals whichever is greater, will receive a short interview. The questions asked will be focused on the areas that required remediation. Interviews will be conducted by phone or in person by DA staff or contractor staff. More extensive interviews will be completed as part of any heightened scrutiny reviews.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

In February 2016, a comprehensive crosswalk was completed comparing the CMS Final Rule HCBS setting requirements to both current and proposed DA and Indiana State Department of Health (ISDH) regulations. This crosswalk focused on the services that had been identified as having possible compliance issues: assisted living, adult day service, adult family care, and structured day programs. The results of this comparison mapped out areas where regulations could include more specific provisions to ensure that sites are compliant with the HCBS requirements. Changes will be made in conjunction with stakeholder groups before the rule is put out for formal public comment.

The ISDH regulations are significant in regards to the Medicaid HCBS service of assisted living. It should be noted though that ISDH does not have licensure or regulations specific to the service of assisted living. ISDH regulations do not actually define or regulate "assisted living". Currently both the A&D and TBI waivers require providers of the service of assisted living to be licensed by ISDH. These providers are therefore licensed as what ISDH rules refer to as residential care facilities. The residential care facility regulations clearly force providers towards institutional characteristics. Even the language used, residents, discharge, admission, etc. all speak to an institutional model. Removing the licensure requirement will not in and of itself make these settings home and community-based. However, it can remove substantial barriers that the regulations create for HCBS providers. A drawback to this option is the need to create a new oversight and monitoring structure in the absence of licensure. Most of the "assisted living" market in Indiana is private pay. According to our best data, Medicaid waiver accounts for about 10% of the licensed residential care capacity in the state. To impact this private pay market with large scale changes to the residential care licensure does not seem appropriate. A provider workgroup has been considering changes to the licensure but DA does not find that those proposed changes go far enough. Furthermore, DA has had extensive discussion with ISDH and they agree that it would not be appropriate to make changes to the residential care licensure driven by the Medicaid requirements for HCBS settings.

DA will be taking a two tiered approach to resolving this conflict. First, there will be an approximately six-month hiatus on new AL provider enrollment beginning in September 2016. During this time DA will enter into a memorandum of understanding (MOU) with ISDH to waive certain provisions of the residential licensure requirements for those providers participating in the Medicaid waiver program. This waiver is allowed under IC 16-28-1-10. DA will work with ISDH and providers to draft this MOU to address all areas identified as non-compliant in the systemic assessment. Additionally, DA staff will undergo training to be prepared to appropriately review and certify new AL providers after the hiatus is over. During this time, DA will conduct webinars for providers exploring each HCBS characteristic and what indicators need to be present as evidence of compliance. This process will address areas of partial compliance in IC 16-28-1-10. The certification process will be developed to include the following language:

- Settings must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Setting must be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Setting must ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- Setting must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.
- Setting must facilitate individual choice regarding services and supports, and who provides them.
- Setting must be a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each individual must have privacy in their sleeping or living unit.
- Units must have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units must have a choice of roommates.
- Individuals must have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals must have the freedom and support to control their schedules and activities, and have access to food any time.

- Individuals must be able to have visitors of their choosing at any time.
- The setting must be physically accessible to the individual.
- Any modifications of the requirements (other than physical accessibility which cannot be modified) must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
 - Identify a specific and individualized need.
 - Document the positive interventions and supports used prior to any modifications to the person-centered plan.
 - Document less intrusive methods of meeting the need that have been tried but did not work.
 - Include a clear description of the condition that is directly proportionate to the specific need addressed.
 - Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - Include the informed consent of the individual.
 - Include an assurance that interventions and supports will cause no harm to the individual.

This will allow existing licensed residential care facilities certified as waiver AL providers to continue participating in the current waiver programs, assuming they do meet all of the HCBS characteristics and pass heightened scrutiny review if they are presumed institutional. This will represent a minimally compliant tier 1 standard.

In the fall of 2016, a workgroup was established consisting of varied representatives of the provider community as well as other advocates and stakeholders. This workgroup will continue to collaborate with the DA to work on compliance evaluation criteria as well as the ISDH MOU. DA will develop a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and possible remediation strategies. Providers, not presumed institutional, will then receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

For tier 2, DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders through the workgroup referenced above to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH. These standards will be based on HCBS characteristics, Money Follows the Person qualified community setting guidelines, and state statute regarding housing with services establishments. Administrative rules will be amended to reflect these standards. Specific waiver, manual, and administrative code language for this new services will include the following requirements:

- must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- must be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- must ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.
- must facilitate individual choice regarding services and supports, and who provides them.\
- must be a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each individual must have privacy in their sleeping or living unit.
- Units must have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units must have a choice of roommates.
- Individuals must have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals must have the freedom and support to control their schedules and activities, and have access to food any time.
- Individuals must be able to have visitors of their choosing at any time.
- The setting must be physically accessible to the individual.
- Any modifications of the requirements (other than physical accessibility which cannot be modified) must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the

person-centered service plan:

Identify a specific and individualized need.

Document the positive interventions and supports used prior to any modifications to the person-centered plan.

Document less intrusive methods of meeting the need that have been tried but did not work.

Include a clear description of the condition that is directly proportionate to the specific need addressed.

Include regular collection and review of data to measure the ongoing effectiveness of the modification.

Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Include the informed consent of the individual.

Include an assurance that interventions and supports will cause no harm to the individual.

Additionally, rate methodology will be reassessed to align with the new service definition and assure that rates are sufficient to build provider capacity. DA hopes to implement this program no later than July 2018. Upon successful implementation, qualified providers and consumers in the current (c) waivers will be migrated to the new program.

-Adult Day Services: Activities provided in a group setting, outside the home; in February of 2015, a self-survey was requested of ADS providers to determine the level of compliance with the HCBS rule. There was a 75% response rate to the self-survey. The results of that self-survey of ADS providers indicates a high percentage of compliance with isolated incidents of remediation needed to achieve the following standards:

-The individual can have visitors at any time

-The individual can have privacy when desired, for instance to take a phone call

-The individual receives activities of daily living (ADL) assistance and other care in areas of the center than allow them appropriate privacy

-The individual's service plan is not posted in a public area

-The individual has a secure place in which to store personal items

-There are no physical barriers which prevent mobility-impaired individuals from accessing restrooms, appliances or other program areas which other participants can access

-Settings are not restricted to individuals of one specific diagnosis or to a specific age group

-Service plans are developed individually, taking into account personal preferences for activities and individualized schedules and routines

-The individual is able to access food at times of their choosing

-The individual is provided opportunities for activities outside the service site to allow interaction with the general community

Current service standards require the service be "...community-based group programs designed to meet the needs of adults with impairments through individual service plans."

Current waiver requirements forbid any use of individual restraint but do not extend this definition to include the restriction of facilities which may have secured perimeters or delayed egress systems. A significant percentage of ADS sites do have secured perimeters that in many cases prevent the ability of participants to leave the building. This will require remediation strategies as described below as well as person centered planning practices to identify individuals who have require such a safety measure as part of their service plan.

There are currently 43 enrolled ADS providers. There are 601 current waiver consumers receiving services in these 39 of these settings. The assessment and remediation strategies delineated below will be implemented to identify and correct deficiencies. Documentation review of ADS providers was completed in February 2016 with 62% of providers responding to the request for documentation, including policies, procedures, handbooks, staff training schedules, lease agreement templates, client rights documents, etc. Some documents were reviewed as part of the site surveys. Any missing elements will be reviewed as part of the review to validate the site's eventual remediation.

Site visits were conducted at 37 of these sites serving current participants. Two sites that did not have active participants at the time of the site visits. These site visits will be completed in the spring of 2017. The site surveys confirmed the issues identified in the self-survey process. There are 3 sites that are co-located with nursing facilities. The DA will conduct a heightened scrutiny review of these sites including public comment and only submit to CMS for consideration as an HCBS site if they are found to have no institutional qualities and they fully comply with the HCBS requirements. The most common areas of non-compliance are:

-Freedom and support to control own schedule and activities.

-Are participants able to freely move about inside and outside the site?

-Are participants able to participate in activities of their choice in the community alone?

-Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible.

-Optimizes individual initiative, autonomy, and independent in making life choices.

-Medications maintained and distributed in a way that promotes individual control and privacy.

-Presence of gates, locked doors, or other barriers preventing individuals' from freely coming and going.

-Access to food at any time - flexibility in meal times.

For the remaining sites, there are no regulatory barriers to remediation. Language in regulations is largely silent or partially compliant in reference to ADS. Language will be enhanced or added to assure that all settings are required to be fully compliant with the HCBS settings requirements. Providers will be notified of the issues identified at each site. The DA will provide

technical assistance to those providers who wish to remediate. For those providers that do not wish to remediate, the DA will work with case managers to provide person centered service planning and support to each individual to transition them into compliant HCBS settings as they may choose. With ADS, the site is not the residence of the individual. So, the transition process would be less complicated. Part of the transition planning must include efforts to recruit more providers in order to fully cover the state and offer choice to consumers. At this time though, the DA believes all providers will participate in remediation, excluding the three sites that are co-located, and no individual transitions will be needed.

Some ADS sites do have secure perimeters, but the DA believes these can be modified to allow participants to come and go freely and only restrict those for whom a person centered planning process has identified an appropriate modification be made (such as to address safety issues caused by a documented issue with wandering due to dementia).

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For ADS settings, 10% of the site's participants, or 10 individuals whichever is greater, will receive a short interview. The questions asked will be focused on the areas that required remediation. Interviews will be conducted by phone or in person by DA staff or contractor staff. More extensive interviews will be completed as part of any heightened scrutiny reviews.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

In the fall of 2016, a workgroup of providers in coordination with DA began developing a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and discussed possible remediation strategies. Providers, not presumed institutional, will then receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

Structured Family Care: A living arrangement in which a participant lives in his or her private home or the private home of a principal caregiver who may be a nonfamily member or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant; support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving; only agencies may be structured family caregiving providers, with the structured family caregiving settings being approved, supervised, trained, and paid by the approved agency provider.

This is not a provider owned or controlled setting as long as the caregiver is a related family member. DA will evaluate each situation individually to determine if the caregiver is not a related family member and if the participant resides in that caregiver's home. There are 4 current SFC providers. 3 of them are serving waiver participants. DA has worked with providers to determine the number of situations in which the caregiver is a non-related individual, and in which that unrelated caregiver owns or leases the residence in which they and the consumer reside. These are estimated to be less than 50 individuals out of the 912 individuals receiving SFC services. These settings are therefore considered by CMS to be provider owned or controlled. They will be assessed and remediated individually for compliance with the HCBS settings requirements. Software changes will be made to record and track this information. These changes will be in place by July 2017. A new checklist will be created for case managers to complete and submit for review with DA review to validate the HCBS nature of the setting prior to initiation of SFC services. SFC is covered by language in 455 IAC 2 and will be covered by the amended version, 455 IAC

2.1. Requirements for provider owned or controlled residential settings will cover any SFC situations that do involve services in the home of an unrelated paid caregiver.

Results and Remediation

None of provider owned or controlled sites were found to be fully compliant based on self-surveys, document reviews, and site surveys to date. All sites have issues that will require remediation. Sites subject to heightened scrutiny will be reviewed again following any remediation and only at that point will DA make the decision whether or not to submit the site for CMS heightened scrutiny review.

Chart summarizing sites and participants in categories of not HCB, presumed not HCB, could be fully compliant, and are presumed HCB and meet requirements without any changes.

Table that summarizes the four more specific groups into which provider owned and controlled sites are classified as a result of the participant experience surveys, site surveys and documentation reviews

Group 1 settings are not HCBS compliant. Provider will be decertified and afforded an appropriate appeal and review process. Participants in these settings will be transitioned to compliant settings.

Group 2 settings will be submitted to CMS through the heightened scrutiny process for approval as a compliant HCBS setting.

Group 3 settings are HCBS compliant and not subject to heightened scrutiny. Participants may remain in this setting with ongoing monitoring measures in place.

Group 4 settings will make modifications in the remediation process and if successfully completed, will be fully compliant. Participants may remain in this setting with ongoing monitoring measures in place. Settings that do not successfully complete remediation will be moved to Group 1.

Based on current information from the completed site surveys,

All AFC sites are in Group 4 and remediation activities will begin in early 2017.

All ADS sites, except the three that are co-located, are also in Group 4 and will begin remediation activities in early 2017.

The three co-located ADS sites will undergo further consideration and review by the Division if they will remain in Group 1 or move to Group 2.

With respect to AL sites:

- At most 24 sites could be in Group 4

- All other AL sites would have to be in Group 1 or Group 2 depending on the degree of co-location and the ability and willingness of the provider to remediate

- No AL sites are found to be in Group 3

For Group 4 providers, a corrective action plan will be developed and monitored to ensure the setting comes into compliance within a specified time period. The timeline will be dependent upon the modifications required but as specified in the table in Section 2, all remediation must be completed no later than July of 2018. Most will be much earlier than that. Specific corrective action(s) will be based on the noncompliance findings. For example, if there is a restriction in place for health or safety reasons that are not documented in the person centered plan, the corrective action would be for the person centered plan to be updated to include the required information consistent with DA policy.

Indiana Code and Indiana Administrative Code already provide for issuance of citation for violations of provider requirements, remedies, and considerations in determining remedy. Specifically, 455 IAC 2-6-4 provides for a monitoring, corrective action process. This process will be utilized in the setting modification process. Code and rule also provide guidance regarding appeal rights and remedies for violations. This will also provide an appeal process for those sites that are found to be institutional and thus will be decertified as waiver providers.

Chart summarizing timelines for remediation activities

DA will develop a remediation plan template that will be distributed to providers of AL, AFC, and ADS in January of 2017.

The template will be provided to them along with the results of their site specific assessments. The plan will require each provider to identify strategies for becoming fully compliant with each HCB requirement. They will need to include milestones and dates as part of the plan. Plans will be due back to the DA by March of 2017. The DA will review all plans and work with the provider on any required changes prior to approval by June 2017. The DA will then enter these on to a master remediation calendar that will be used by DA staff to follow up with providers on their progress. DA staff will regularly check the calendar for milestones expected to be reached and contact the provider through email to request confirmation of the successful completion of the milestone. If there are barriers to completion this will afford the provider an opportunity to seek technical assistance from DA staff on those challenges.

When a provider believes they have completed remediation, they will be required to notify the DA. DA will then complete any validation activities required. These will vary based on the nature of the non-compliant issue. Some validation efforts will have to take place overtime to assure that remediation strategies have been fully implemented. Validation may take the form of document review, interviews with staff, participants, case managers, families or others, as well as site visits. All or some of these methods may be used again depending on the nature of what is being validated. For instance, if the primary non-compliance issue is the use of an appropriate lease. That remediation can largely be validated through document review and may not require a site visit. Other issues, like the ability to have visitors, might include a document review of a new or revised policy as well as site visits, perhaps multiple to observe visitor activity, as well as participant interviews by phone or in person. Providers who fail to meet milestones or fail to communicate regularly with the DA during the remediation process or who fail to cooperate during the remediation validation process will be placed in a "suspend certification" status. During this time, they can continue to serve current participants but cannot accept any new participant until the remediation issues are resolved. If they cannot be resolved, the provider will be notified of non-compliance and beneficiaries will be notified of the need to select another provider and setting. These changes will be completed by March of 2019. (More detail provided under the Relocation of Beneficiaries sections)

Heightened Scrutiny

Using site assessment information, the DA will determine which settings are presumed institutional and subject to heightened scrutiny. This will include settings with the following characteristics:

- A waiver setting that is co-located in the same building as a provider of inpatient care or treatment; and/or

- A waiver setting that is operating under the same institutional license as a provider of inpatient care or treatment; and/or

- A waiver setting that is secured for the purpose of providing care to persons with dementia.

In January 2017, these providers will all receive a letter from the DA, notifying them that they have been identified as presumed institutional. They will be informed that, should they wish to continue providing services after March 2019, they will need to remediate any institutional characteristics and provide evidence of having done so to the DA. Such evidence shall include, but will not be limited to: policy documentation, copies of lease/residency agreements; organizational charts, specialized training in

dementia care and/or person-centered care and planning; redacted service plans and the surrender of any institutional license. This evidence will be validated through participant survey input, site visits by DA or DA contractor staff, and public comment on each site requesting heightened scrutiny review.

If a setting has institutional qualities that cannot be addressed by modifications by the provider, the setting will be considered institutional (Group 1). If a setting does not have institutional qualities, it will be reviewed for HCBS settings characteristics. Heightened scrutiny requests for any sites the DA believes have overcome the presumption of institutionalization will be submitted by December of 2017 or sooner if the provider has completed remediation to overcome the presumption of institutionalization.

Relocation of Beneficiaries

The DA has not yet determined the number of individuals who may be affected by relocation. Estimates are included on the chart above, but the final number will be determined as provider remediation plans are submitted and reviewed and validated. For Group 1 sites, a transition plan will be established both for the site and each individual participant. The site transition plan shall include a list of participants requiring transition, a plan for communicating with these individuals and their person centered support circle throughout the transition period, a timeline for decertification of the provider, and regular progress reports to be submitted to DA. Currently available appeal and administrative review processes will be provided to participants impacted, as well as to the providers that must be decertified.

The participant specific transition plan will be developed and monitored by the waiver case manager. It will provide for appropriate notice to the individual and their person centered support circle regarding the site's noncompliance, the action steps that will occur, and procedural safeguards available to them. The case manager will work with the participant and their representatives to examine all available options. Timelines will be established to support transitioning individuals to a compliant setting no later than December 2018, provided they wish to remain in the waiver program. Beginning summer of 2017, training will be provided to case managers and providers to ensure a smooth transition for the participant(s) requiring transition.

Beneficiary Communication Timeline

DA will seek to notify beneficiaries in a timely way. Notices should not be so early as to spark unnecessary panic for individuals and their families; yet the notice should give them as much time as possible to plan for a potential move. Additionally, DA does not want to alarm beneficiaries that may be confused by letters they receive without explanation. Beginning in October of 2017 through July of 2018, case managers will hand deliver notices to beneficiaries residing in sites that will not or cannot become compliant. Most notices would be delivered by January of 2018 but later notices may be made if a provider is failing to make satisfactory progress towards remediation. In some cases, that may not become apparent until closer to the July 2018 target date for completion of remediation.

The new HCBS option that is part of tier 2 strategy is intended to be available by July 2018 and may offer expanded provider choice and options for some beneficiaries. Beneficiaries will be provided with options counseling on all setting options available to them. Beneficiaries will also be notified of potential sources of advocacy (including Indiana Disability Rights, ombudsman, the Arc, other advocacy organizations) along with their right to appeal. The transition plan developed by the case manager will be completed as part of the person centered planning process involving the individual's circle of support. The transition plan document will be an addendum to the person centered service plan. Transition plans will be reviewed by DA as part of service plan review.

All transition plans should be submitted to the DA within 60 days of beneficiary notification. DA will complete their review within 30 days. The case manager will be able to document and track milestones in the case management system. The system will allow DA staff to monitor beneficiaries still in non-compliant settings as we approach March of 2014. DA staff will provide technical support and assistance to case managers as they aid the beneficiary in the transition process.

Ongoing Compliance and Monitoring of Settings

The Person Centered Monitoring Tool (PCMT), formerly the 90 Day Review tool, is administered by the case manager for every waiver participant, face-to-face, every 90 days. This will be the primary compliance monitoring tool. To complete the PCMT, the case manager conducts an interview with the participant as well as anyone else the participant has identified. This tool has already been updated to include an assessment of the service and setting as experienced by the individual and reports have been developed to identify specific settings for which a service participant has indicated any state of non-compliance within the setting. These reports will be reviewed on a monthly basis and corrective actions required at that time.

Additionally, in 2016 DA began participating in the National Core Indicators survey for the A&D population (NCI-AD). NCI-AD is being administered to a statistically valid sampling of participants in all of the HCBS programs, Medicaid and non-Medicaid. This survey tool replaces the Participant Experience Survey (PES) that had been used with waiver participants for many years. The NCI-AD focuses on how participants experience the services they receive and how they impact the quality of life they experience. A number of the NCI-AD questions crosswalk to the characteristics of a HCBS setting. A crosswalk is provided below of PCMT items and NCI-AD questions to HCB characteristics. The DA also monitors providers and service delivery through Provider Compliance Reviews (PCR) and Participant-Centered Compliance Reviews (PCCRs). These assessments will continue throughout the transition process and will be updated to include the new standards as the State moves through the transition period.

The Participant Centered-Compliance Review is conducted for a statistically significant random sample of waiver participants each year. This review focuses on how the individual experiences the services they receive and how each individual's chosen providers comply with waiver standards in the delivery of services. The PCCR sample size is based on a 95% confidence level,

5% margin of error, and 50% response distribution using the Raosoft tool. Distribution is proportionate to waiver participants by geographic areas of the state and all service types were included. TBI waiver sample size is approximately 132 using the above formula and an estimated total population of 200. A&D Waiver is approximately 375 using the above formula and an estimated total population of 15,000. Because the PCCR uses a random sampling method, it is not guaranteed that each participant will receive a review within any particular time period.

The PCR is conducted every three years for all waiver providers not licensed by the ISDH. The PCR focuses on the provider's policies and procedures and looks for evidence that those are being followed.

With both types of reviews, all negative findings must be addressed through a "corrective action plan" (CAP) which allows the provider to describe how it intends to address the problem. The DA then either approves the CAP, or works with the provider to develop an acceptable plan. DA intends to use these same tools and processes to assess and correct many of the areas which are identified as non-compliant with the HCBS rule, and will also continue to use updated versions of these tools to assure compliance with the HCBS rule over the long-term.

Offering Non-Disability Specific Setting Options

Case managers are required, as part of options counseling, to explain to individuals the various settings under which they may receive HCBS. This requirement will be documented in revisions to 455 IAC 2. Case managers will receive training as part of their orientation and ongoing training on this requirement and best practices for meeting it. Individuals will be supported in the decision making process so that their person centered service plan will include their selection of the setting in which they receive services. This may well be their current residence, private home or apartment, or a relative's home, or a congregate, provider owned or controlled setting that has the characteristics of an HCB setting.

Crosswalk of NCI-AD and PCMT to HCBS Setting Characteristics – chart outline aligned of NC-AD and person centered monitoring tool questions to HCBS settings characteristics

Training and Technical Assistance (continued in additional section)

*****The
Following Addendum is Added Per CMS Directive

****The State assures that the settings transition plan for this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Indiana's Statewide Transition Plan Version 5 with initial approval is available at: <https://secure.in.gov/fssa/files/IN%20FSSA%20HCBS%20STP%20-%20Technical%20Corrections%20V5%202016%2011%2004.pdf>

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Main Attachment Two 05.09.2017

DA has identified four groups that require trainings on HCB characteristics: DA staff, case managers, providers of AL, ADS, and AFC services, and contractors completing provider and participant surveys. DA staff include individuals involved with the review of new provider sites, individuals that will complete remediation validation, individuals who conduct compliance reviews, individuals who review service plans, and individuals who monitor incident reports. All have been trained on the required HCB characteristics with the level appropriate to their role in the process. The DA Director and Deputy Director have taken a hands on approach in this training as the subject matter experts. A more formal online training will be created for use by DA staff as new staff come onboard. This training will be available by March 2017.

DA is also developing online training tools for case managers. Trainings will focus on general overview of the HCB settings requirements, the use of the PCMT for ongoing compliance monitoring, tips for monitoring compliance during onsite visits to provider owned and controlled settings, the completion of person centered modifications to HCB setting requirements, and the case manager's role in any heightened scrutiny submissions. Online trainings will be supplemented with webinars for Q&A and in person trainings largely in a train the trainer model.

For providers, the DA will offer semiannual in-person training opportunities, at least quarterly webinars, and template documents for remediation plans. DA will also make staff available to the extent necessary for one-on-one technical assistance to providers. DA will work with providers to identify and share best practices in their remediation efforts.

The DA uses contractors currently to complete PCCR and NCI-AD interviews. Other contractors may be used as part of the remediation validation reviews as well. Any contract staff will have to complete the same training as DA staff prior to completing any assessments of sites or interviews with participants.

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

It is the intention to assist each provider in reaching full compliance and assist each participant with realizing the full benefits of

the HCBS rule. To achieve these outcomes, it is imperative that the providers and participants, as well as their advocates and representatives, are included in each step of the process. Steps taken to date include:

Several meetings occurred with trade associations representing AL and ADS providers.

During the month of October 2015, Division staff met with case managers in regional training sessions to introduce them to the HCBS requirements and to open dialog as to how they will be involved and asked them to encourage their consumers and advocates to participate in transition planning and processes.

Five regional forums were scheduled in November 2014. These were conducted on-site at provider-owned AL facilities to meet with participants and their family members regarding the rule, the transition process, and opportunities to participate in that process.

All DA HCBS waiver providers were invited to a provider training day November 10, 2014. This day included an “all-provider” session on the HCBS rule, as well as an extended session to gather provider input into the process.

The DA has engaged with individual providers throughout the assessment process, explaining the need for self-surveys and emphasizing the need for public participation, both in scheduled forums and ongoing. The DA will continue this individual approach as opportunities arise.

In February 2016, the DA met again with AL and ADS providers and the Alzheimer’s Association specifically on the topic of secure memory care units.

Meetings and discussions have been ongoing with provider associations, in particular assisted living provider associations.

Training webinars will be developed by DA staff directed to audiences of case managers as well as providers of AL, ADS, AFC, and structured day programming.

As a result of the comments received on this update, DA has reached out to include Indiana Disability Rights (IDR) more directly in this process.

October 2016 through January 2016 two workgroups will collaborate on remediation plan template design and technical assistance materials that outline future requirements for ADS and AL.

DA held an open provider forum in December 2016 to continue provider education on the settings rule, the state’s transition plan, and the upcoming remediation process. Special breakout sessions were held for ADS, AFC, and AL providers to focus on a review of the survey results and the most common areas in need of remediation as well as best practices for coming into compliance.

The DA has identified some specific areas for key stakeholder participation in the transition plan. We will consider the process to be dynamic and will be looking for opportunities to include stakeholders, particularly DA HCBS waiver participants, in the development and implementation as it evolves.

We have identified “Key Stakeholders” to be the DA HCBS waiver participants, their family members and advocates; HCBS waiver providers, along with their various trade associations; case managers and their managing entities, the 16 Area Agencies on Aging, the Long-Term Care Ombudsman and local representatives; and established advocacy groups representing senior citizens and individuals with disabilities.

PUBLIC INPUT

Indiana’s Version 6 Statewide Transition Plan was open for public comment for 30 days, January 18, 2017 through February 17, 2017. The comment period allowed all HCBS members, potential members, providers and other stakeholders an opportunity to provide input to the plan.

Version 6 of the Statewide Transition Plan and related materials are available at FSSA’s Home and Community-Based Services Final Rule website. Indiana provided public notice in print and electronic form through the Indiana Register, print articles in newsletters disseminated by advocacy groups and trade organizations, newsletters and list serves. Paper copies were available in all local Division of Family Resources (DFR) offices and upon request. Written comments were received by email via HCBSrulecomments@fssa.in.gov, or by mail to:

Public Comment SUMMARY:

DA solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; the A&D (A&D) Waiver.

The comments resulted in changes incorporated in the STP.

PUBLIC COMMENTS:

Comment: Commenter has concerns that the HCBS settings rule creates further limitations for residential options by denying true choice and potentially very beneficial opportunities.

Response: Thank you for your comments. DA agrees it is important to expand and not limit choices while working with the framework of the programs and services available.

Comment: Commenter requested to know the criteria Division of Aging will use to determine if the Structured Family Care giving is provider owned or controlled.

Response: Thank you for your comments. To your question on how DA will determine if SFC is provider owned and controlled, that will hinge primarily on whether the paid caregiver is a related or unrelated individual. But in either case, there are core provisions of the Settings Rule that apply in ALL settings and those will always be monitored for compliance.

Comment: Would like to encourage DA to include more people with disabilities or participants of those services and advocacy groups in the DA initiative to design a new program to replace or augment the service of assisted living.

Response: DA appreciates the need to involve consumers and their families in the stakeholder process. DA continues to work on ways to do that effectively and is always open to suggestions.

Comment: The continued use of a 90-day checklist may be limiting and not give the full picture of the individual's true needs and wants. Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participants wants and needs, especially if this tool is to be used to help determine a settings on-going compliance with HCBS rules.

Response: DA has appreciated your comments before on the limitations of the 90 day checklist and hope to engage with you and other stakeholders on a thorough review of this tool in the coming year.

Comment: Commenter cited the Federal Requirement: Right to privacy, dignity, respect, and freedom from coercion and restraint. Commenter would encourage DA to restrict a provider's ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen. Apart from requiring a written record to be made when either measure is used, the statute does not contain reporting requirements or review measures. The application of the new HCBS requirements are an ideal time for the Division to take a stronger approach to protecting the dignity and well-being of consumers. DA should also include a prohibition against involuntary seclusion, or forced social isolation by any provider in code (not just in the ISDH health facilities rule).

Federal Requirement: Settings optimize, but do not regiment individual initiative . . .

455 IAC 2.1-6-4(2) - a provider should not "allow" the person to engage in decision-making and self-determination. Rather, that should be a given, automatic standard. Rather the facility should respect the person's right to make decisions and engage in self-determination. "Allow" implies that the facility can remove that allowance.

455 IAC 2.1-6-6(b)(1) - participants should be able to lock their unit, not just their room.

Physical accessibility - it's not just the room that would need to be accessible, but the entire unit, including common areas, the bathroom, kitchen, etc.

Response: DA agrees that it would be inappropriate for the provider to act as guardian and will consider language for draft rule. A number of your suggestions are directly related to rule language and DA will consider them as comments in that process as well.

Comment: Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participants' choice and participants should be allowed to opt-out if they choose.

Commenter also encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout.

Finally, commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: DA agrees that the use of trained surveyors and interviewers will be critical in obtaining reliable information.

Comment: Relocation of beneficiaries - participants should also be notified of potential sources of advocacy organizations along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Notifying individuals who may need to be relocated about advocacy organizations available to them is a great idea. DA has revised the STP on page 60 to add language pertaining to notifying beneficiaries about advocacy organizations.

Comment: Ongoing Compliance and Monitoring – Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. IDR continues to have reservations regarding the heavy reliance DA plans to place upon the 90-day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the DA should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist.

Commenter also encourages inclusion of participants and advocacy groups in developing trainings as well.

Response: Thank you for your comments. DA appreciates the need to involve consumers and their families in the stakeholder process. We continue to work on ways to do that effectively and are always open to suggestions.

Comment: Commenter noted Indiana Protection & Advocacy Services on page 64 should be corrected to Indiana Disability Rights.

Response: DA will make the change on page 64 to reflect Indiana Disability Rights.

Comment: One commenter noted: implicit in the statewide transition plan is the assumption that providers cannot comply with both the current Indiana Residential Care Facility (RCF) licensure rules and the Settings Rule. However, a review of several individual provider reviews (mailed to providers in February 2017) failed to identify any instance where a provider's remediation would conflict with RCF licensure rules.

Response: Thank you for your comments. DA would note that the Settings Rule requirement to provide for the responsibilities and rights of tenant, in a legally enforceable agreement (§441.301(c)(4)(vi)(A)) was not addressed in the survey tool and will need to be addressed in every remediation plan. That is one significant area of conflict. DA has specifically identified the following areas of conflict:

1. Transfer and Discharge of Residents (410 IAC 16.2-5-0.5(f) and 410 IAC 16.2-5-1.2(r))
2. Residency Agreements (410 IAC 16.2-5-1.2(g))

3. Person Centered Planning (410 IAC 16.2-5-1.2(j)(2))

4. Visitors (410 IAC 16.2-5-1.2(cc))

Comment: One commenter noted: while it may be appropriate to include proposed Division of Aging rule language, the STP should include recognition that Indiana's rule promulgation process will be followed and in so doing, some of the proposed language may be revised.

Response: DA has included proposed rule language in the transition plan a timeline for rule promulgation. Some of that language has been refined already as a result of our assisted living workgroup. DA thanks you for being part of that group.

Comment: In the Statewide Transition Plan, Indiana has indicated that SFC is not a provider owned-or controlled setting as long as the participant lives in a home that is owned or rented by themselves or by a caregiver who is a family member. This interpretation of the Home and Community Based Services Final Rule (HCBS Final Rule) implies that when participants live in a private home that is owned or rented by an un-related caregiver, this home is considered a provider owned or controlled setting. When a setting is considered provider owned or controlled, additional components of the HCBS Final Rule apply. We strongly disagree with this interpretation of the HCBS Final Rule. SFC providers do not own or control the home where SFC is provided.

As you know, caregivers can be related or unrelated, and SFC pays for the care provided to participants and the clinical support provided to caregivers. SFC rules govern how care is provided to participants and how caregivers are supported by SFC agency providers, both components are based on individualized consumer and caregiver assessments and outlined in person centered care plans.

Response: Thank you for your comments on structured family care. DA has continued to seek clarification from CMS on its intent with regard to some of the relationships you have listed here as examples of "unrelated" caregivers.

Comment: One commenter noted as the DA designs a new Medicaid HCBS, bear in mind that the program needs to be some type of certification or license. The terms, certification or license, allow for the Residents to access their long term care benefits and VA benefits for "Assisted Living".

Response: Thank you for your comments. Most of your comments related to specific language for new administrative code/rule language. Some of your comments are directed at current language which is in the draft process now for our new rule. DA will consider all your comments in drafting that language as well as in the transition plan.

Continued from Main 6-I Public Input for IN.210.05.03

Public Comment: One commenter noted one of the greatest difficulties faced by individuals with disabilities living in the community is identifying and securing quality caregivers. By 2020, direct care workers are expected to comprise the largest national workforce.

DA response: DA agrees that there are serious workforce challenges in long term services and supports. DA is committed to working with providers, consumers, advocates, and other stakeholders to discover and begin to address the root causes of these workforce issues.

Public Comment: One commenter noted attracting decent caregivers is already difficult. Consider that common hiring platforms require job posters to offer prospective caregivers no less than \$10 per hour. This makes it difficult for Hoosiers with consumer-directed care, arguably the most community-based option available under the A&D Waiver, to hire the needed staff to live independently; the State will not reimburse caregivers at this rate. This dynamic jeopardizes the ability of people with disabilities to live independently, as well as safely, in their communities.

DA response: DA agrees that it needs a more holistic review of all services and associated rates. DA will be undertaking a more complete review and looking more at comprehensive HCBS program design over the coming months. This would include consideration of DA's consumer directed care options.

Public Comment: One commenter encourages the Division of Aging to reconsider raising the reimbursement rate only for assisted living providers. An across-the-board rate increase would not only be the most equitable solution, but is also sorely needed by Waiver participants receiving home health services.

DA response: DA agrees that it needs a more holistic review of all services and associated rates. DA will be undertaking a more complete review and looking more at comprehensive HCBS program design over the coming months.

Public Comment: The A&D Waiver amendment seeks to increase the number of unduplicated waiver participants in the program and increase reimbursement to Assisted Living ("AL") communities under the A&D waiver program by 5%. Both elements of the A&D Waiver amendment are crucial to the ongoing efforts to "rebalance" Indiana's Medicaid program by providing more access to HCBS. The commenter has been a pro-active partner of the DA and the Family and Social Services

Administrations efforts to grow HCBS without severe and negative impact on the skilled and long term care nursing services provided by nursing facilities, otherwise labeled as institutional services.

Yes, more growth is needed, which is why the commenter has partnered with the DA and OMPP to expand HCBS. Part of that growth can and should continue in the current A&D Waiver program, but other program authorities must be examined and we look forward to diving into those opportunities with the DA and OMPP. An undisputed resource in the growth of HCBS are AL communities.

As the DA and OMPP move forward on expansion of HCBS services, the commenter believes it is also important to allow the community based providers, including AL communities, to flourish with government payment as they have been able to do in the private market. What this speaks to is the need to appropriately regulate, but not over-regulate or stifle these businesses with government processes that have become very burdensome and expensive in other settings such as nursing facilities. Specifically, we believe that rate setting methodology for HCBS services, including AL communities, can be based on market data and not subjected to a time consuming and expensive cost reporting system. More burden will not attract the needed providers in this segment of services. CMS permits alternatives to using cost reports for rate setting purposes and we urge the DA and OMPP to use the market rate analysis alternative.

DA response: Thank you for your comments.

Public Comment: One commenter offers comment for inclusion in the public record relating to the proposed amendment dated February 20, 2017. The commenter supports both elements of the amendment:

1. Expanding Aged and Disabled waiver capacity to increase the number of maximum number of unduplicated waiver participants for Wavier Year 4 and Waiver Year 5; and
2. A 5% increase in the assisted living Medicaid waiver reimbursement rate effective July 1, 2017.

The proposed amendment to increase of waiver slots will assist Indiana in its long-term rebalancing efforts. The proposed 5% increase of the waiver reimbursement rate for assisted living providers is a first step toward catching up with operating cost increases since 2008. During the nine years since 2008, only a single 2 % rate increase has been approved for assisted living Medicaid providers under A&D waiver while four relevant inflation indices have increased by 13.9% to 18.4%.

The increase in the cap will assist Indiana in its prolonged efforts at rebalancing long-term care spending. While the number of Indiana's A&D waiver participants has grown over several years, the percentage of Indiana's Medicaid long-term care spending on HCBS has changed very little. During 2014, 18.1% of Indiana's total Medicaid long-term care spending for the aged and disabled population was spent on HCBS. This percentage amount represents a decrease from 20.3% in 2010. The national average for HCBS spending in 2014 was 40.7 % of total Medicaid long-term care spending on the aged and disabled population, up from 37.2% in 2014.

As of FY/ WY 2014, Indiana has not made satisfactory progress in rebalancing is Medicaid spending toward HCBS for the aged and disabled population.

Assisted living is a key element in the HCBS rebalancing strategy, as assisted living provides 24- hour on-site support to meet the scheduled and unscheduled needs of aged and disabled persons. Since 2008, the reimbursement rate paid to Indiana's assisted living Medicaid providers has lagged far behind relevant cost indices and now the per diem rate paid to Medicaid providers is 24% to 40%% below what Indiana assisted living providers are paid by private sector consumers. Reflecting the impact of this differential, only 27% of assisted living providers accept Medicaid, a stark contrast with percentage of skilled nursing facilities that accept it.

During the period 2003 to 2008, Indiana's Medicaid program consistently adjusted the rates paid to all providers under its Aged and Disabled waiver program, including rate changes effective April 2003, July 2005, July 2006 and July 2008. During the nine (9) years since July 2008, the reimbursement rate to assisted living providers increased only once, a 2% rate increase effective January 1, 2014.

This 2% rate for AL providers increase over 9 years is substantially less than the inflationary increases of other relevant indices, including:

- A 13.6% increase in the Consumer Price Index for the Midwest, the CPU-U Midwest for January 2009 to January 2017. (Source: Bureau of Labor Statistics).
- A 14.2% increase in the average monthly wages for persons employed in the assisted living, nursing home and continuing care retirement community sector for the period 4Q 2007 to 4Q 2015. (Source: U.S. Census Bureau, NAICS code 623 for nursing care, residential facilities and CCRCs in the State of Indiana).
- A 15.4% increase in the maximum Federal SSI payment amount for an individual, from \$637 per month in 2008 to \$735 per month in 2017, (Source: Social Security Administration).
- A 18.4% increase for in the average monthly charges in Indiana for private pay assisted living in a one bedroom assisted living, during the period 2008 to 2016, from \$2,979 to \$3,525 per month. (Source: Genworth Annual Cost of Care Survey of that incorporates more than 6,200 completed surveys in 440 regions of the nation, including thirteen metro areas of Indiana.) The costs to Indiana consumers for private pay assisted living during 2014 to 2016 indicate that private pay rates are 24-40% greater than the \$2,851 per month total payment to assisted living Medicaid waiver providers. The three sources indicate average private pay assisted living rates in Indiana are:
- 2016 edition of the Genworth Annual Cost of Care Survey states average Indiana assisted living costs are \$3,528 per month is

23.7% greater than the Medicaid monthly revenues;

- 2014 average costs of assisted living in Indiana by the “A Place for Mom” website is \$3,825 per month which is 34% greater than the Medicaid revenues; and

- \$3,995 per month as the average of 35 assisted living properties in six Indiana metro markets as reported in market studies by Valerie S. Kretchmer & Associates completed in 2015 and 2016. This is 40% greater than the average rate paid to Indiana providers of assisted living Medicaid waiver services.

The initial 5% adjustment for assisted living Medicaid waiver providers would be a first step towards compensating for the rate’s erosion vis-à-vis inflation and other cost indices over the past nine years. In moving the waiver rate towards private pay rates, the State will induce more providers to accept Medicaid, thus ensuring broader diffusion of AL services for Medicaid recipients. Widespread availability of such services (to the degree available to the general population) is a goal articulated in the Social Security Act. Absent this and future rate increases, Indiana will continue to experience poor availability of assisted living services to Medicaid recipients and will not realize its long-held goal of rebalancing Medicaid spending.

DA response: Thank you for your comments.

Public Comment: The commenter supports the waiver amendment, and appreciates DA's ongoing support of the assisted living component of the HCBS program. From a financing perspective, broader market forces are working against us. Rising interest rates and the recent significant reduction in the value of low income housing tax credits (proceeds from the sale of tax credits act as equity in the project) are making it increasingly difficult to structure economically feasible financing for these communities. Additionally, construction and operational costs have steadily increased since we started this effort some five years ago. These trends seem unlikely to reverse in the near term. The combination of the A&D waiver and LIHTCs has proved to be an effective means of providing affordable assisted living to those most in need. Without regular adjustment and sensitivity to market changes, the combination will lose its effectiveness. The commenter encourages CMS to approve the requested waiver increased participation and reimbursement, so we may continue to create appropriate affordable housing for frail seniors. We also urge DA to revisit this issue on a regular basis and/or establish a mechanism to adjust reimbursement and participation in response to market changes.

DA response: Thank you for your comments.

Appendix A: Waiver Administration and Operation

- 1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- ☒ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- ☒ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Aging

(Complete item A-2-a).

- ☐ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Family Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer the waiver.

The waiver is operated by FSSA's Division of Aging (DA), a division under the single State Medicaid agency. The FSSA's Office of Medicaid Policy and Planning (OMPP), a division under the single state Medicaid Agency, is responsible for monitoring DA's operation of the waiver.

The following lists many of the functions for which each division has accepted responsibility:

Division of Aging:

- Developing a Quality Assurance Plan and submitting quality reports to OMPP
- Maintenance of an incident reporting and complaints tracking and resolution process
- Training and documentation of initial and ongoing qualifications of waiver case managers
- Drafting Medicaid waivers, amendments and renewals
- Establishing provider standards and promulgating rules that include such standards
- Process waiver provider applications for approval and re-approval
- Prepare and present testimony in administrative appeals
- Assist with preparation of annual financial reports

Office of Medicaid Policy and Planning:

- Review and approve provider claims and respond to inquiries related to claims payment
- Retains final authority for rate setting and coverage criteria for all Medicaid services
- Enrolls qualified providers into Medicaid
- Ongoing and periodic reporting and analysis of claims data
- Provider Education of proper billing procedures
- Review and approve manuals, modules, bulletins, communications and policy
- Review, approve and submit Medicaid waivers, amendments and renewals
- Prepare and submit annual waiver financial reports
- Participates in quality improvement processes

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

A contract exists between the Medicaid Agency and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these entities conduct waiver operational functions are available to CMS upon request through FSSA (as applicable).

Specific to the operational and administrative functions of this waiver, the following activities are conducted by contracted entities.

FISCAL AGENT is responsible for:

- Reimbursement of claims for authorized waiver services submitted by authorized waiver providers;
- Qualified providers are enrolled as providers of waiver services;
- Provider training is performed periodically and technical assistance is provided concerning waiver requirements;
- and
- Monthly and quarterly reporting for all contracted activities is compiled and submitted timely.
- Collecting and analyzing waiver paid claims data
- Compiling this data for the annual waiver reporting to CMS

UTILIZATION MANAGEMENT FUNCTIONS:

The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR contractor. The Family and Social Services Administration (FSSA) has expanded its program integrity activities by using a multipronged approach to SUR activity that includes provider self-audits, contractor desk audits, and full on-site audits. The SUR contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims.

The FSSA or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, the FSSA may at any time conduct audits to assure appropriate administration and delivery of services under the service agreement.

The following program integrity and SUR activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on SUR policy and procedures is available in Chapter 13 of the IHCP Provider Manual.

The State of Indiana's Program Integrity has an agreement with the FSSA Audit Group to investigate allegations of Medicaid HCBS waiver provider fraud, waste, and abuse. Program Integrity and FSSA Audit are part of FSSA Quality & Compliance so there is a natural level of collaboration and cooperation between the two groups. FSSA Audit's auditors are knowledgeable of each waiver's service definitions, documentation standards, provider qualifications, and any required staffing ratios making them well equipped to investigate allegations of wrongdoing in the waiver programs. Program Integrity does not have staff with this kind of expertise.

Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, Program Integrity forwards it to FSSA Audit to begin their research and audit process. To begin investigating these allegations, FSSA Audit works with Program Integrity to vet the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance FSSA Audit determines how to best validate the accuracy of the allegation. FSSA Audit may choose to audit a statistically valid random sample of consumers and then Program Integrity's Fraud Abuse and Detection (FADS) vendor will pull such a sample for their audit.

FSSA Audit conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with Program Integrity so Program Integrity can track that the allegation was reviewed and follow-up action taken as necessary.

The FSSA maintains oversight throughout the entire PI process. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

On a more proactive level, FSSA Audit also routinely meets with each of the State Medicaid Agency's units that

operate the waivers to identify and conduct audits on providers that have been identified as potentially not billing correctly.

ACTUARIAL CONTRACTOR is responsible for
 -Completing cost neutrality calculations for the waiver
 -Budget planning and forecasting, and waiver development

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☐ **Not applicable**
☒ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- ☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Area Agencies on Aging through their qualified case managers are responsible for preparing a written service plan for each individual waiver participant. The service plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging and/or the Office of Medicaid Policy and Planning. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Each of the sixteen (16) Area Agencies on Aging are responsible for disseminating information regarding the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, conducting level of care evaluation activities, recruiting providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements.

Independent case managers are also responsible for preparing a written service plan for each individual waiver participant. The service plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging and/or the Office of Medicaid Policy and Planning. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

FSSA is responsible for assessing performance of the Medicaid Fiscal Agent Contractor's provision of training and technical assistance concerning waiver requirements and, in collaboration with DA, the execution of the Medicaid Provider Agreements for enrollment of waiver providers.

-The DA monitors the Area Agencies on Aging (AAAs) and non-AAA Case management entities through the electronic case management system, monthly communication with AAAs to verify compliance with performance and on site follow up through quality assurance surveys using the Person Centered Compliance Tool (PCCT) and the Provider Compliance Tool (PCT).

-The DA monitors the Quality Improvement contract for the administration of the Person Centered Compliance Tool.

-The State Medicaid Agency has oversight responsibility of the Financial Analysis contractor.

-The oversight of the performance of Surveillance Utilization Review (SUR) Contractor's Fraud and Abuse Detection System (FADS) contract is performed by Program Integrity, under the direct supervision of the FSSA Chief Compliance Officer.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Performance based agreements are written with the Area Agencies on Aging and are audited by the Indiana State Board of Accounts and the Family and Social Services Administration's Audit Unit. These audits are performed on a biannual basis.

The provider relations specialist oversees and assures that providers are appropriately enrolled through the Medicaid Fiscal Contractor. The required Waiver Enrollments and Updates Weekly Report is sent by the Fiscal Contractor to the provider relations specialist. Providers are to be enrolled by the dedicated Fiscal Contractor provider enrollment specialist within an average of thirty (30) days from receipt of the completed provider agreement paperwork.

The DA provider relations specialist forwards complaints about the timeliness or performance of the Fiscal Contractor to the OMPP Director of Provider Relations.

FSSA Compliance exercises oversight and monitoring of the deliverables stipulated within the Fraud and Abuse Detection System (FADS) contract in order to ensure the contracting entity satisfactorily performs waiver auditing functions under the conditions of its contract. Reporting requirements are determined as agreed upon within the fully executed contract. The FADS Contractor is required to submit recommendations for review based on their data.

During 2011, the State of Indiana formed the Benefit Integrity Team comprised of both state and contract staff. This team meets biweekly to review and approve audit plans, provider communications and make policy recommendations to affected program areas. FSSA Compliance oversees the contractor's aggregate data to identify common problems, determine benchmarks and offer data to providers to compare against aggregate data.

Final review and approval of all audits and audit-related functions falls to FSSA Program Integrity. The direction of the FADS process is a fluid process, allowing for modification and adjustment in an on-going basis to ensure appropriate focus.

The State Medicaid Agency oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DA. The DA's Provider Relations Specialist position monitors the Fiscal Contractor and assures that providers are appropriately enrolled through the Medicaid fiscal agent. The required Waiver Enrollments and Updates Weekly Report is sent by the fiscal agent to the Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent within an average 30 calendar days from receipt of the completed provider agreement paperwork.

The State Medicaid Agency contracts with an Actuarial contractor, who provides financial analysis and actuarial consultant services for Indiana Medicaid. The contractor performs Medicaid enrollment and expenditure forecasts, by program, which aids in monitoring expenses and supports state budgeting. Forecasting is done on both a paid basis and service incurred basis. Trends are determined and vary by population as appropriate. Trends are developed taking into account historical Indiana Medicaid trends, State and National trends, trends used by the CMS Office of the Actuary, and future program changes. Final documentation from the actuarial contractor includes an executive summary, detailed results, and sources of data, methodologies, and assumptions.

The actuarial contract, which is currently monitored by Finance, is not a performance based contract.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete

the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

A.1 Number of percent of waiver participants enrolled by the Division of Aging in accordance to state established criteria. Numerator: Total number of waiver participants enrolled by the Division of Aging in accordance to state established criteria. Denominator: Total number of waiver participants enrolled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Waiver enrollment report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.2 Number and percent of active waiver participants compared to the approved waiver capacity. Numerator: Total number of active waiver participants. **Denominator:** Total number of CMS approved waiver slots.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Unduplicated member reports (lag)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually <input checked="" type="checkbox"/> Continuously and Ongoing <input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.3 Number and percent of quarterly LOC reports submitted to the OMPP by the Division of Aging within the required time period. Numerator: Total number of quarterly LOC reports submitted within the required time period. Denominator: Total number of quarterly LOC reports due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LOC Quarterly Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

A.4 Number and percent of quarterly service plan reports submitted to OMPP by the Division of Aging within the required time period. Numerator: Total number of quarterly service plan reports submitted within the required time period. Denominator: Total number of service plan reports due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quarterly Service Plan reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

A.5 Number and percent of provider reviews completed by the Division of Aging within specified timeframe outlined in the waiver. Numerator: Total number of provider reviews completed by the Division of Aging within specified timeframe. Denominator: Total number of provider reviews due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DA Provider Review Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.6 Number and percent of waiver policies and procedures developed by the Division of Aging that were approved by OMPP prior to implementation. Numerator: Total number of waiver policies and procedures developed by the Division of Aging that were approved by OMPP prior to implementation. Denominator: Total number of waiver policies and procedures implemented.

Data Source (Select one):

Presentation of policies or procedures

If 'Other' is selected, specify:

DA Provider Policy and Procedure Manual

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.7 Number and percent of providers assigned a Medicaid provider number according to

the required timeframe specified in the contract with the fiscal contractor. **Numerator:** The number of providers assigned a Medicaid provider number by the fiscal contractor according to the required timeframe specified in the contract. **Denominator:** The total number of providers assigned a Medicaid provider number.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Weekly Waiver Provider Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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Performance Measure:

A.8 Number and percent of enrolled waiver providers who met all provider enrollment requirements corresponding to the executed contract. Numerator: Total number of enrolled waiver providers who met all provider enrollment requirements. Denominator: The total number of waiver service providers who were enrolled by the fiscal contractor.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Weekly waiver provider report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: Fiscal Intermediary	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

A.1-A.6: OMPP meets at least monthly with DA to review and aggregate data, respond to questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. OMPP exercises oversight over the performance of the waiver function by the DA, contractors and providers through on-going review and approval of the waiver, revisions to the plan, policies, as well as participation in numerous councils and committees. OMPP also participates with DA in all conference calls with CMS pertaining to the waiver.

A-7-A.8: The State Medicaid Agency meets at least monthly with the fiscal contractor to review reports, respond to questions, identify areas of concern and resolve issues to ensure contractual compliance. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP).

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	0	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	0	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Participants who are in the Disabled (Physical) and Disabled (Other) target subgroups are seamlessly transitioned to the Aged target subgroup upon reaching age 65.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☒ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- ☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- ☐ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- ☐ The following percentage that is less than 100% of the institutional average:

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	15265
Year 2	16081
Year 3	18778
Year 4	21153
Year 5	22519

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- ☒ The State does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- ☐ Not applicable. The state does not reserve capacity.
- ☒ The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes
Community transition of institutionalized person due to "Money Follows the Person" initiative

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Community transition of institutionalized person due to "Money Follows the Person" initiative

Purpose (*describe*):

The State reserves capacity within the waiver to implement the vision of moving individuals from institutional care to home and community-based services. This vision is being realized through home and community-based services and dollars awarded to Indiana for a demonstration grant, "Money Follows the Person".

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care and determined, based upon the number of waiver slots, the realistic number of individuals that could be transitioned in year 1 through 5. It was determined that we could move a total of 1725 individuals over the course of the 5 years of this waiver renewal.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	345
Year 2	345
Year 3	345
Year 4	345
Year 5	345

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
 - ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Applicants will enter the waiver on the following basis:

1. Eligible individuals transitioning off 100% state funded budgets to the waiver, transitioning from nursing facilities to the waiver, or discharging from in-patient hospital settings to the waiver, by date of application; followed by
2. Other eligible individuals applying to the waiver on a first come first serve basis by date of application.

Individuals being served under any other 1915(c) home and community-based services waiver shall not be concurrently served under the Aged & Disabled Waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- ☒ §1634 State
☐ SSI Criteria State
☐ 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- ☐ No
☒ Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ Low income families with children as provided in §1931 of the Act
☒ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☐ Optional State supplement recipients
☒ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☒ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
☒ Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☒ Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage

Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

42 CFR 435.110 Parents and other caretaker relatives

42 CFR 435.118 Infants and children under age 19

42 CFR 435.145 Children for whom adoption assistance or foster care maintenance payments are made (under title IV-E of the Act)

42 CFR 435.150 Former Foster Care Children; Sec. 1902(a)(10)(A)(i)(IX)

42 CFR 435.226 Independent Foster Care Adolescents; Sec. 1902(a)(10)(A)(ii)(VII)

42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements

Sec 1925 of the Act --Transitional Medical Assistance

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*
- ☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- ☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

- ☐ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- ☒ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (2 of 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):
☒ **The following standard included under the State plan**

Select one:

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☒ The special income level for institutionalized persons

(select one):

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**
- ☐ A percentage of the FBR, which is less than 300%

Specify the percentage:

- ☐ A dollar amount which is less than 300%.

Specify dollar amount:

- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ Other standard included under the State Plan

Specify:

- ☐ The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ The following formula is used to determine the needs allowance:

Specify:

☐ **Other**

Specify:

ii. Allowance for the spouse only (select one):

☒ **Not Applicable**

☐ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (select one):

☐ **SSI standard**

☐ **Optional State supplement standard**

☐ **Medically needy income standard**

☐ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

☐ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

☐ **Not Applicable (see instructions)**

☒ **AFDC need standard**

☐ **Medically needy income standard**

☐ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

☐ **The amount is determined using the following formula:**

Specify:

☐ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☐ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☒ **The State does not establish reasonable limits.**
- ☐ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**

- ☒ **The special income level for institutionalized persons**
- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- ☐ **The following formula is used to determine the needs allowance:**

Specify formula:

- ☐ **Other**

Specify:

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- ☒ **Allowance is the same**
- ☐ **Allowance is different.**

Explanation of difference:

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☐ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☒ **The State does not establish reasonable limits.**
- ☐ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (6 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (7 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility**B-6: Evaluation/Reevaluation of Level of Care**

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- ☒ **The provision of waiver services at least monthly**
☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ☐ Directly by the Medicaid agency
- ☐ By the operating agency specified in Appendix A
- ☐ By an entity under contract with the Medicaid agency.

Specify the entity:

- ☒ **Other**
Specify:

All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. All initial level of care approvals are reviewed and verified by the operating Agency- Division of Aging (DA) staff prior to service implementation.

Re-evaluations completed by AAA case managers are approved or denied by AAA management staff. Re-evaluations completed by non-AAA case managers are approved or denied by DA Staff.

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor.

Case managers performing level of care evaluations and case management supervisors must meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility level of care process by the Division of Aging or designee.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (455 IAC 2-3-1). The Eligibility Screen is required to be completed by the case manager as part of the LOC packet. An E-screen will not be accepted by the computer system if all of the pages of the E-screen have not been addressed. Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician, physician assistant, or nurse practitioner recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

The final Level of Care determination is documented in the section of the Transmittal for Medicaid Level of Care Eligibility form (State Form 46018-HCBS7).

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.




- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

INITIAL EVALUATIONS

All applicants for the Waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. Waiver participants must meet the minimal LOC requirements for that of a nursing facility. All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. Indiana has established the Eligibility Screen, a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (455 IAC 2-3-1). Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician, physician assistant, or nurse practitioner recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

LOC evaluations are structured and monitored to assure that decisions are appropriately rendered. The waiver database contains certain edits and audits that prevent submission of an initial plan of care until all LOC requirements are met. The FSSA's DA investigates and resolves plan of care and level of care issues prior to making final decision.

RE-EVALUATIONS

LOC evaluations are made as part of the individual's annual waiver renewal process, or more often if there is a significant change in the individual's condition which impacts LOC.

The above mentioned documents are the same for LOC re-evaluation process, except the 450B is not required. In addition, all LOC re-evaluations for clients managed by the Area Agency on Aging (AAA) are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. All case management supervisors meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility level of care process by the Division of Aging or designee.

For those participants who have chosen to be case managed by non-AAA case managers the LOC re-evaluation decisions are required to be reviewed by and a decision rendered by designated staff members within the Division of Aging (DA). Designated staff members within the DA meet all case management qualifications as detailed in Appendix C or have received training in the nursing facility LOC process by the Division of Aging or designee.

The case manager maintains copies of all written notices and electronically filed documents related to an individual's level of care determination and the individual's right to a Medicaid Fair Hearing. The case manager must ensure that the Level of Care Review Form is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database system the date the Level of Care Review Form was sent to the applicant or participant.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ Every three months
☐ Every six months
☐ Every twelve months
☒ Other schedule

Specify the other schedule:

Every twelve months or more often as needed.

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
☐ The qualifications are different.

Specify the qualifications:




- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The Division of Aging is using a reporting tool that generates a report at least sixty (60) days prior to the annual level of care (LOC) reevaluation to advise a case manager that reviews are due. The report was designed to establish trends and needed education regarding annual level of care. The reports are monitored by the Supervisor of the Waiver Operations Unit and coordinated with the Assistant Director of the Waiver Operations Unit.

Notifying the case managers at least sixty (60) days prior to the annual LOC reevaluation due date will assist case managers in returning the annual LOC reevaluation within the required timeframe. The DA is able to monitor which case managers submit a late annual reevaluation and therefore will be able to provide educational training and assistance to those case managers who are consistently late in their submissions.

The DA runs a monthly report that identifies participants whose reevaluation are due within sixty (60) days and sends the listing to case managers. After the due date, the DA re-runs the report that identifies the case managers who are late in submitting the LOC reevaluation and notifies the case managers that the reevaluation is due within fifteen (15) days. If the reevaluation is not received by the DA within fifteen (15) days of notification, the DA submits the listing of delinquent case managers to the Quality Assurance/Quality Improvement (QA/QI) Unit within the DA for corrective action.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The evaluation and reevaluation documentation is maintained for a minimum of three years within the electronic case management database within the Division of Aging.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.1 Number and percent of new enrollees who received a Level of Care (LOC) evaluation prior to enrollment. Numerator: Number of new enrollees who received a

LOC evaluation prior to enrollment. Denominator: Number of new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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- b. **Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.2 Number and percent of enrolled participants who are reevaluated annually.

Numerator: Number of enrolled participants who are reevaluated annually.

Denominator: Number of participants with annual LOC reevaluations due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-assurance:** The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.3 Number and percent of LOC determinations made where the LOC criteria was accurately applied. Numerator: Number of waiver LOC determinations made where the LOC criteria was accurately applied. Denominator: Number of waiver LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic case management database system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

LOC determinations are facilitated through a module in the electronic case management application referred to as the E-Screen. This tool is structured to assure that LOC criteria is consistently applied and other automated features prevent service plan approval prior to LOC approval, and provide prompts to assure redeterminations are conducted timely. Additionally, discovery reports are monitored by the Division of Aging (DA) Quality Assurance Unit to identify any individual instances of non-compliance, which are remediated individually and analyzed for systemic issues. Specific remediation processes are identified for instances of non-compliance for each performance measure. All documentation of resolution activities will be maintained within the electronic case management database.

B.1: If the DA, or any other entity, identifies any instance of a new applicant not having received a level of care evaluation prior to enrollment the DA will ascertain if any related claims had been made and deny these. The waiver case manager will be required to immediately conduct a proper evaluation and re-enter this into the system. If it is identified that the individual does not meet the criteria for the approved level of care, the case manager will be advised to refer the individual for any other services which may be available. The DA will report any finding of evidence of malfeasance to FSSA Program Integrity for review. All LOC decisions are subject to the applicant's rights to appeal and have a Medicaid Fair Hearing.

B.2: Findings of overdue redeterminations are individually reviewed to determine cause and circumstance. The case manager will be required to immediately conduct a redetermination and enter this in the electronic case management system. Any systemic failure to complete LOC redeterminations can result in referral for handling as a formal complaint through which the responsible entity may be sanctioned, up to and including termination as a case management provider. If redetermination reveals that the individual does not meet the approved LOC category, any claims submitted will be denied back to the date of expiration of the prior LOC period. The case manager will be advised to refer the individual for any other services which may be available. The individual will also be informed in writing of their rights to appeal and have a Medicaid Fair Hearing.

B.3: In any discovery finding where a participant received an evaluation where LOC criteria was not accurately applied, the DA will require that a reevaluation be conducted with findings verified by supervisory or DA personnel. If there is any evidence that the evaluation was intentionally inaccurate, the individual completing the evaluation will be referred to the DA for handling as a formal complaint with potential sanctions up to and including termination as a waiver provider. Instances attributable to lack of knowledge of LOC criteria, either individually or on the part of a business entity, will require re-training as specified by the DA.

If redetermination reveals that the individual does not meet the approved LOC category, any claims submitted will be denied back to the date of expiration of the prior LOC period. The case manager will be advised to refer the individual for any other services which may be available and the individual participant will be informed in writing that they have the right to request a formal Appeal and are entitled to a Medicaid Fair Hearing to dispute any LOC determination decision.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The case manager is responsible for explaining the HCBS waiver services available to the individual requesting services. The case manager assesses the individual and completes a service plan. On the service plan there is a section regarding freedom of choice. The freedom of choice language is as follows and is required to be signed by the individual.

"A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in an institutional care setting. I understand the alternatives and have been given the opportunity to choose between waiver services in a home and community-based setting and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in a home and community-based setting and institutional care."

In addition, the applicant/participant is informed that participants in the waiver cannot receive traditional Medicaid services through Medicaid's risk-based managed care system.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms will be maintained by the case management entity and within the electronic case management database within the Division of Aging.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003): FSSA's Office of Medicaid Policy and Planning and the Division of Aging address the needs of individuals with limited English

in a variety of ways:

- Public informational materials regarding waiver services will be available in Spanish and English.
- The case manager identifies the individual's preferred language of communication.
- Case managers and service providers are expected to have oral interpretation available for most common languages in their service areas. Bilingual providers are preferred. Oral interpretation is achieved either through:
 - (a) bilingual staff, contractual interpreters, telephone interpreters; or
 - (b) the use of family/friends as interpreters only when/if the person needing service is aware of the option of one provided at no cost. An individual needing services will not be required to use a family member as an interpreter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service	
Statutory Service	Adult Day Service	
Statutory Service	Attendant Care	
Statutory Service	Case Management	
Statutory Service	Homemaker	
Statutory Service	Respite	
Other Service	Adult Family Care	
Other Service	Assisted Living	
Other Service	Community Transition	
Other Service	Environmental Modification Assessment	
Other Service	Environmental Modifications	
Other Service	Health Care Coordination	
Other Service	Home Delivered Meals	
Other Service	Nutritional Supplements	
Other Service	Personal Emergency Response System	
Other Service	Pest Control	
Other Service	Specialized Medical Equipment and Supplies	
Other Service	Structured Family Caregiving	
Other Service	Transportation	
Other Service	Vehicle Modifications	

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:**Sub-Category 1:**

04 Day Services

04050 adult day health

**Category 2:****Sub-Category 2:**

04 Day Services

04060 adult day services (social model)

**Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Adult Day Service (ADS) are community-based group programs designed to meet the needs of adults with impairments through individual service plans. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

Participants attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced, and Intensive.

ALLOWABLE ACTIVITIES

BASIC ADULT DAY SERVICES (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities
- Health assessment and intermittent monitoring of health status
- Monitor medication or medication administration
- Appropriate structure and supervision for those with mild cognitive impairment
- Minimum staff ratio: One staff for each eight individuals
- RN Consultant available

ENHANCED ADULT DAY SERVICES (Level 2) includes:

Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Health assessment with regular monitoring or intervention with health status
- Dispense or supervise the dispensing of medication to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments
- Minimum staff ratio: One staff for each six individuals
- RN Consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision

INTENSIVE ADULT DAY SERVICES (Level 3) includes:

Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or supervision with all ADLs and personal care
- One or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments

- Minimum staff ratio: One staff for each four individuals
- RN Consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to deal with participants' psycho-social needs

SERVICE STANDARDS

- Adult Day Services must follow a written service plan addressing specific needs determined by the client's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form

Case manager must give the completed Adult Day Service Level of Service Evaluation to the provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Services are allowed for a maximum of 10 hours per day.

ACTIVITIES NOT ALLOWED:

- Any activity that is not described in allowable activities is not included in this service
- Services to participants receiving Assisted Living waiver service

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Adult Day Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency ▼

Provider Type:

FSSA/ DA approved Adult Day Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard (*specify*):

Must comply with the Adult Day Services Provision and Certification Standards, as follows:

DA approved

455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval

455 IAC 2 Provider Qualifications: General requirements

455 IAC 2 Provider Qualifications: General requirements for direct care staff

455 IAC 2 Procedures for Protecting Individuals

455 IAC 2 Unusual occurrence; reporting

455 IAC 2 Transfer of individual's record upon change of provider

455 IAC 2 Notice of termination of services

455 IAC 2 Provider organizational chart

455 IAC 2 Collaboration and quality control

455 IAC 2 Data collection and reporting standards

455 IAC 2 Quality assurance and quality improvement system

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Maintenance of personnel records

455 IAC 2 Adoption of personnel policies

455 IAC 2 Operations manual

455 IAC 2 Maintenance of records of services provided

455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

08 Home-Based Services

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Attendant Care Services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow aging adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

ALLOWABLE ACTIVITIES

Homemaker activities that are essential to the individual's health care needs in order to prevent or postpone institutionalization when provided during the provision of other attendant care services.

Provides assistance with personal care which includes:

- Bathing, partial bathing
- Oral hygiene
- Hair care including clipping of hair
- Shaving
- Hand and foot care
- Intact skin care
- Application of cosmetics

Provides assistance with mobility which includes:

- Proper body mechanics
- Transfers
- Ambulation
- Use of assistive devices

Provides assistance with elimination which includes:

- Assists with bedpan, bedside commode, toilet
- Incontinent or involuntary care
- Emptying urine collection and colostomy bags

Provides assistance with nutrition which includes:

- Meal planning, preparation, clean-up

Provides assistance with safety which includes:

- Use of the principles of health and safety in relation to self and individual
- Identify and eliminate safety hazards
- Practice health protection and cleanliness by appropriate techniques of hand washing
- Waste disposal, and household tasks
- Reminds individual to self-administer medications
- Provides assistance with correspondence and bill paying
- Escorts individuals to community activities that are therapeutic in nature or that assist with developing and maintaining natural supports

SERVICE STANDARDS

- Attendant Care services must follow a written service plan addressing specific needs determined by the individual's assessment
- If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the service plan to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services

DOCUMENTATION STANDARDS

- Identified need in the service plan

- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Attendant Care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Attendant Care services will not be provided to household members other than to the participant
- Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Attendant Care services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method *(check each that applies):*

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Personal Services Agency
Agency	Licensed Home Health Agency
Individual	FSSA/DA approved Attendant Care Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Attendant Care

Provider Category:

Agency ▼

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care****Provider Category:**

Agency ▼

Provider Type:

Licensed Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

IC 16-27-4

Certificate (specify):**Other Standard (specify):**

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care****Provider Category:**

Individual ▼

Provider Type:

FSSA/DA approved Attendant Care Individual

Provider Qualifications**License (specify):**

IC 16-27-4

Certificate (specify):**Other Standard (specify):**

DA approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 General requirements for direct care staff

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements

455 IAC 2 Personnel Records

455 IAC 2-6-1 Provider qualifications: becoming an approved provider; maintaining approval

455 IAC 2-6-2 (a)(1)(B) Provider qualifications: general requirements

455 IAC 2-11-1 Property and personal liability insurance

IC 12-10-17.1-10 Registration; prohibition

IC 12-10-17.1-11 Registration requirement

IC 12-10-17.1-12 Registration by the division; duties of the division

The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

Compliance with IC 16-27-4, if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Case Management ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

01 Case Management

01010 case management ▼

Category 2:

Sub-Category 2:

 ▼

Category 3:

Sub-Category 3:

 ▼

Category 4:

Sub-Category 4:

 ▼

Service Definition (Scope):

Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's service plan.

ALLOWABLE ACTIVITIES

- Assessments of eligible individuals to determine eligibility for services, functional impairment level, and

corresponding in-home and community services needed by the individual

- Development of service plans to meet the individual's needs
- Implementation of the service plans, linking individual with needed services, regardless of the funding source
- Assessment and care planning for discharge from institutionalization
- Annual reassessments of individual's needs
- Periodic updates of service plans
- Monitoring of the quality of home care community services provided to the individual
- Determination of and monitoring the cost effectiveness of the provisions of in-home and community services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance as described in Appendix E-1-j for those participants who have selected self-directed attendant care

SERVICE STANDARDS

- Case Management Services must be reflected in the service plan of the individual
- Services must address needs identified in the service plan

DOCUMENTATION STANDARDS

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)

Clinical/Progress Documentation:

- Services must be outlined in the service plan
- Evidence that individual requires the level of service provided
- Documentation to support services rendered

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Case Management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services, or by any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging that has been granted permission by the Family and Social Services Administration Division of Aging to provide direct services to individuals

Note: Common ownership exists when an individual, individuals, or any legal entity possess ownership or equity of at least five percent in the provider as well as the institution or organization serving the provider. Control exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.

- Independent case managers and independent case management companies may not provide initial applications for Medicaid Waiver services
- Reimbursement of case management under Medicaid Waivers may not be made unless and until the individual becomes eligible for Medicaid Waiver services. Case management provided to individuals who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service
- Case management services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person

- ☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/ DA approved Case Management Individual
Agency	FSSA/DA approved Case Management Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual ▾

Provider Type:

FSSA/ DA approved Case Management Individual

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

DA, or its designee, approved
 455 IAC 2 Documentation of qualifications
 455 IAC 2 Case Management
 Liability Insurance

Training in the nursing facility level of care process by the Division of Aging or designee

Education and work experience

- a qualified mental retardation professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430
- a registered nurse with one year's experience in human services; or
- a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, Nursing, or Health & Human Services; or
- a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or
- a Master's degree in a related field may substitute for the required experience

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging


Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency **Provider Type:**

FSSA/DA approved Case Management Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

DA, or its designee, approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 Procedures for protecting individuals

455 IAC 2 Unusual occurrence; reporting

455 IAC 2 Transfer of individual's record upon change of provider

455 IAC 2 Notice of termination of services

455 IAC 2 Provider organizational chart

455 IAC 2 Collaboration and quality control

455 IAC 2 Data collection and reporting standards

455 IAC 2 Quality assurance and quality improvement system

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Documentation of qualifications

455 IAC 2 Maintenance of personnel records

455 IAC 2 Adoption of personnel policies

455 IAC 2 Operations manual

455 IAC 2 Maintenance of records of services provided

455 IAC 2 Case Management

Training in the nursing facility level of care process by the Division of Aging or designee

Education and work experience

-an individual continuously employed as a Case Manager by an Area Agency on Aging (AAA) since January 1, 1990

-a qualified mental retardation professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430

-a registered nurse with one year's experience in human services; or

-a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, Nursing or Health & Human Services; or

-a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or

-a Master's degree in a related field may substitute for the required experience

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Homemaker ▼

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

08 Home-Based Services

08050 homemaker ▼

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Homemaker services offer direct and practical assistance consisting of household tasks and related activities. Homemaker services assist the individual to remain in a clean, safe, healthy home environment. Homemaker services are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

ALLOWABLE ACTIVITIES

1. Provides housekeeping tasks which include:

- dusting and straightening furniture
- cleaning floors and rugs by wet or dry mop and vacuum sweeping
- cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
- maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
- laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
- changing linen and making beds
- washing insides of windows
- removing trash from the home
- choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
- clearing primary walkway

2. Provides assistance with meals or nutrition which includes:

- shopping, including planning and putting food away
- making meals, including special diets under the supervision of a registered dietitian or health professional

3. Runs the following essential errands:

- grocery shopping
- household supply shopping
- prescription pick up

4. Provides assistance with correspondence and bill paying

SERVICE STANDARDS

- Homemaker services must follow a written service plan addressing specific needs determined by the client's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Assistance with hands on services such as eating, bathing, dressing, personal hygiene, and activities of daily living
- Escort or transport individuals to community activities or errands
- Homemaker services provided to household members other than to the participant
- Cleaning up of the yard, defined as lawn mowing, raking leaves
- Homemaker services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, the legal guardian of the participant, or by any member of the participant's household
- Services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	Licensed Personal Services Agency
Individual	FSSA/DA approved Homemaker Individual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency ▼

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (*specify*):

IC 16-27-1

IC 16-27-4

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency ▼

Provider Type:

Licensed Personal Services Agency

Provider Qualifications**License (specify):**

IC 16-27-4

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Individual ▼

Provider Type:

FSSA/DA approved Homemaker Individual

Provider Qualifications**License (specify):**

IC 16-27-4

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Provider qualifications: becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: general requirements

455 IAC 2 Liability insurance
 455 IAC 2 Professional qualifications and requirements
 455 IAC 2 Personnel Records

Compliance with IC 16-27-4, if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Respite ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

09 Caregiver Support

09012 respite, in-home ▼

Category 2:

Sub-Category 2:

05 Nursing

05020 skilled nursing ▼

Category 3:

Sub-Category 3:

 ▼

Category 4:

Sub-Category 4:

 ▼

Service Definition (Scope):

Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations: in an individual's home or in the private home of the caregiver.

The level of professional care provided under respite services depends on the needs of the individual.

- An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse
- An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision; ostomy care; and tube feedings should be considered for respite nursing services

ALLOWABLE ACTIVITIES

- Home health aide services
- Skilled nursing services

SERVICE STANDARDS

- Respite services must follow a written service plan addressing specific needs determined by the individual's assessment
- The level of care and type of respite will not exceed the requirements of the service plan- therefore, skilled nursing services will only be provided when the needs of the individual warrant skilled care
- If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered
- Data Record of staff to individual service documenting the complete date and time in and time out, and the number of units of service delivered that day
- Each staff member providing direct care or supervision of care to the individual makes at least one entry on each day of service describing an issue or circumstance concerning the individual
- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included (example: if a nurse is required to perform the service then the RN title would be included with the name)
- Any significant issues involving the individual requiring intervention by a health care professional, or case manager that involved the individual also needs to be documented

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Respite shall not be used as day/child care to allow the persons normally providing care to go to work
- Respite shall not be used as day/child care to allow the persons normally providing care to attend school
- Respite shall not be used to provide service to a participant while participant is attending school
- Respite may not be used to replace services that should be provided under the Medicaid State Plan
- Respite will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Respite must not duplicate any other service being provided under the participant's service plan
- Respite service to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite**Provider Category:**

Agency ▼

Provider Type:

Licensed Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Family Care

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

02 Round-the-Clock Services

02023 shared living, other

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet NF level of care and whose needs can be met in a home-like environment. The participant and up to three (3) other participants who are elderly or have physical and/or cognitive disabilities who are not

members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the AFC provider.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid Waiver case manager, and the AFC provider. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet NF level of care, and whose needs can be met in an AFC setting.

Another goal is to preserve the dignity, self-respect and privacy of the participant by ensuring high quality care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as the needs of the participant change.

Participants selecting Adult Family Care service may also receive Case Management service, Adult Day Service, Specialized Medical Equipment and Supplies, and Health Care Coordination through the waiver.

ALLOWABLE ACTIVITIES:

The following are included in the daily per diem for Adult Family Care:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Transportation for necessary appointments that include transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Consumer focused activities that are appropriate to the needs, preferences, age, and condition of the individual participant
- Assistance with correspondence and bill paying if requested by participant.

SERVICE STANDARDS

- Adult Family Care services must follow a written service plan addressing specific needs determined by the individual's assessment
- Services must address the participant's level of service needs
- Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home
- Backup services must be provided by a qualified individual familiar with the individual's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care
- AFC provides an environment that has the qualities of a home, including privacy, comfortable surroundings that include furnishings as specified in the Adult Family Care Survey Tool, and the opportunity to modify one's living area to suit one's individual preferences
- Rules managing or organizing the home activities in the AFC home that are developed by the provider or provider-contracted primary caregiver, or both and approved by the Medicaid waiver program must be provided to the individual prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under state and federal law
- Consumer-focused activity plans are developed by the provider with the participant or their representative
- AFC emphasizes the participant's independence in a setting that protects and encourages participant dignity, choice and decision-making while preserving self-respect
- Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant

DOCUMENTATION STANDARDS:

- Identified need in the service plan
- Services outlined in the service plan
- Requires completed Adult Family Care Level of Service Evaluation form. (Case manager must give the completed Adult Family Care Level of Service Evaluation form to the provider)
- Daily documentation to support services rendered by the AFC to address needs identified in the Level of Service

Evaluation form:

- participant's status
- updates
- participation in consumer focused activities
- medication management records, if applicable

• Maintenance of participant's personal records to include:

1. social security number
2. medical insurance number
3. birth date
4. all medical information available including all prescription and non-prescription drug medication currently in use
5. most recent prior residence
6. hospital preference
7. mortuary (if known)
8. religious affiliation and place of worship, if applicable

• Participant's personal records must contain copies of all applicable documents:

1. advance directive
2. living will
3. power of attorney
4. health care representative
5. do not resuscitate (DNR) order
6. letters of guardianship

NOTE: if applicable, copies must be:

- placed in a prominent place in the consumer file; and
- sent with the consumer when transferred for medical care

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**ACTIVITIES NOT ALLOWED:**

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Adult Family Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

The Adult Family Care service per diem does not include room and board.

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Personal Emergency Response System, Attendant Care, Home Delivered Meals, Nutritional Supplements, Pest Control, Community Transition, or Structured Family Caregiving services furnished to a participant selecting Adult Family Care services as these activities are integral to and inherent in the provision of Adult Family Care Services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Adult Family Care Agency
Individual	FSSA/DA approved Adult Family Care Individual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Family Care****Provider Category:**

Agency ▼

Provider Type:

FSSA/DA approved Adult Family Care Agency

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards.

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider Qualifications: General Requirements

455 IAC 2 General requirements for direct care staff

455 IAC 2 Procedures for protecting individuals

455 IAC 2 Unusual occurrence; reporting

455 IAC 2 Transfer of individual's record upon change of provider

455 IAC 2 Notice of termination of services

455 IAC 2 Provider organizational chart

455 IAC 2 Collaboration and quality control

455 IAC 2 Data collection and reporting standards

455 IAC 2 Quality assurance and quality improvement system

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Transportation of an individual

455 IAC 2 Documentation of qualifications

455 IAC 2 Maintenance of personnel records

455 IAC 2 Adoption of personnel policies

455 IAC 2 Operations manual

455 IAC 2 Maintenance of records of services provided

455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Family Care****Provider Category:**

Individual ▼

Provider Type:

FSSA/DA approved Adult Family Care Individual

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards.

DA approved

- 455 IAC 2 Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider Qualifications; General requirements
- 455 IAC 2 General requirements for direct care staff
- 455 IAC 2 Procedures for protecting individuals
- 455 IAC 2 Unusual occurrence; reporting
- 455 IAC 2 Transfer of individual's record upon change of provider
- 455 IAC 2 Notice of termination of services
- 455 IAC 2 Provider organizational chart
- 455 IAC 2 Collaboration and quality control
- 455 IAC 2 Data collection and reporting standards
- 455 IAC 2 Quality assurance and quality improvement system
- 455 IAC 2 Financial information
- 455 IAC 2 Liability insurance
- 455 IAC 2 Transportation of an individual
- 455 IAC 2 Documentation of qualifications
- 455 IAC 2 Maintenance of personnel records
- 455 IAC 2 Adoption of personnel policies
- 455 IAC 2 Operations manual
- 455 IAC 2 Maintenance of records of services provided
- 455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assisted Living


HCBS Taxonomy:


Category 1:**Sub-Category 1:**


02 Round-the-Clock Services

02013 group living, other

Category 2:**Sub-Category 2:**


Category 3:**Sub-Category 3:**


Category 4:**Sub-Category 4:**


Service Definition (Scope):

Assisted living service is defined as personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health (ISDH), in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

To maintain the integrity of a community based setting, participants reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect. While some assisted living facilities are located on the campus of or adjacent to a nursing facility, they are not located on the grounds of or immediately adjacent to a public institution.

Participants selecting Assisted Living service may also receive Case Management service, Specialized Medical Equipment and Supplies service and Community Transition services through the waiver.

ALLOWABLE ACTIVITIES

The following are included in the daily per diem for Assisted Living Services:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Therapeutic social and recreational programming
- Transportation for non medical services

SERVICE STANDARDS

- Assisted Living services must follow a written service plan addressing specific needs determined by the client's assessment.

DOCUMENTATION STANDARDS

- Services outlined in the service plan

- Evidence that individual requires the level of service provided
- Documentation to support service rendered
- Negotiated risk agreement, if applicable
- Requires completed Assisted Living Level of Service Evaluation form
- Case manager must give the completed Assisted Living Level of Service Evaluation form to the provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- The Assisted Living service per diem does not include room and board.
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Nutritional Supplements, Pest Control, or Structured Family caregiving services furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency ▼

Provider Type:

Licensed Assisted Living Agencies

Provider Qualifications

License (*specify*):

IC 16-28-2

Certificate (*specify*):

Other Standard (*specify*):

DA approved

410 IAC 16.2-5

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

Sub-Category 1:

16 Community Transition Services

16010 community transition services ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Community Transition services include reasonable, set-up expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move.

Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the per diem. For those receiving this service under the waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA) or DA approved provider who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

- Security deposits that are required to obtain a lease on an apartment or home
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, microwave, bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy

SERVICE STANDARDS

- Community Transition services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for Community Transition is limited to a lifetime cap for set up expenses, up to \$1,500.

ACTIVITIES NOT ALLOWED

- Apartment or housing rental or mortgage expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs
- Regular utility charges
- Services to participants receiving Adult Family Care waiver service

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Community Transition Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency ▼

Provider Type:

FSSA/DA approved Community Transition Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements
 455 IAC 2 Transfer of individual's record upon change of provider
 455 IAC 2 Financial information
 455 IAC 2 Liability insurance
 455 IAC 2 Transportation of an individual
 455 IAC 2 Professional qualifications and requirements; documentation of qualifications
 455 IAC 2 Maintenance of personnel records
 455 IAC 2 Adoption of personnel policies
 455 IAC 2 Operations manual
 455 IAC 2 Maintenance of records of services provided
 455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modification Assessment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services

17030 housing consultation ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Environmental Modification Assessment Services will be used to objectively determine the specifications for an environmental modification that is safe, appropriate and feasible in order to ensure accurate bids and workmanship.

The Environmental Modification Assessment will assess the home for minor physical adaptations to the home, which as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

The Assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. Upon completion of the specifications, and review of feasibility, the Assessor will prepare and submit the project specifications to the case manager and individual for the bidding process and be paid first installment of \$300 for completion of home specifications. Once the project is complete, the Assessor, consumer and case manager will then inspect the work and sign-off indicating that it was completed per the agreed upon bid and be paid the final installment of \$200. This payment is not included in the actual environmental modification cost category and shall not be subtracted from the participant's lifetime cap of \$15,000. The case management provider entity will be responsible for maintaining related records that can be accessed by the state.

ALLOWABLE ACTIVITIES

- Evaluation of the current environment, including the identification of barriers which may prevent the completion of desired modifications.
- Reimbursement for non-feasible assessments.
- Review of participant's plan of care
- Drafting of specifications: Electrical, Plumbing & Interior Framing
- Preparation/submission of specifications
- Post project inspection/approval

SERVICE STANDARDS

- Need for environmental modification must be indicated in the participant's plan of care
- Modification must address the participant's level of service needs
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for Environmental Modification Services.
- Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An annual cap of \$500 is available for Environmental Modification Assessment services.

ACTIVITIES NOT ALLOWED

- Environmental Modification Assessment services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Payment will not be made for Environmental Modifications under this service.
- Payment will not be made for an Environmental Modification Assessment for the maintenance, repair or service of an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DA approved Environmental Modification Assessment Individual
Individual	Architect

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:

Individual ▾

Provider Type:

FSSA/DA approved Environmental Modification Assessment Individual

Provider Qualifications**License (specify):**

IC 25-20.2 Home Inspector

Certificate (specify):

Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders)

OR

Executive Certificate in Home Modifications (University of Southern California)

Other Standard (specify):

DA Approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:

Individual ▾

Provider Type:

Architect

Provider Qualifications**License (specify):**

IC 25-4

Certificate (specify):

Other Standard (specify):

DA Approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and perm

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptation

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Environmental modifications are minor physical adaptations to the home, as required by the individual's service plan, which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All environmental modifications must be approved by the waiver program prior to services being rendered.

A. Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.

B. Environmental modifications shall be authorized only when it is determined to be medically necessary and shall

have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home;
2. The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);

C. Requests for modifications at two or more locations may only be approved at the discretion of the Division of Aging director or designee.

D. Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need(s).

A. Adaptive door openers and locks - limited to one (1) per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.

B. Bathroom Modification - limited to one (1) existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:

1. removal of existing bathtub, toilet and/or sink;
2. installation of roll in shower, grab bars, ADA toilet and wall mounted sink;
3. installation of replacement flooring, if necessary due to bath modification.

C. Environmental Control Units - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

D. Environmental safety devices limited to:

1. door alarms;
2. anti-scald devices;
3. hand held shower head;
4. grab bars for the bathroom.

E. Fence - limited to 200 linear feet (individual must have a documented history of elopement);

F. Ramp - limited to one per individual primary residence, and only when no other accessible ramp exists:

1. In accordance with the Americans with Disabilities Act (ADA) or ADA Accessibility Guidelines (ADAAG), unless this is not in the best interest of the client;
2. Portable - considered for rental property only;
3. Permanent;
4. Vertical lift - may be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used.

G. Stair lift - if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB;

H. Single room air conditioner (s) / single room air purifier (s) - if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan:

1. There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
2. The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

I. Widen doorway - to allow safe egress:

1. Exterior - modification limited to one per individual primary residence when no other accessible door exists;
2. Interior - modification of bedroom, bathroom, and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).

J. Windows - replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason (s);

K. Upon the completion of the modification, painting, wall coverings, doors, trim, flooring etc. will be matched (to the degree possible) to the previous color/style/design;

L. Maintenance - limited to \$500.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:

1. Requests for service must detail parts cost and labor cost;
2. If the need for maintenance exceeds \$500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

M. Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

SERVICE STANDARDS

A. Environmental Modification must be of direct medical or remedial benefit to the individual;

B. Environmental Modifications must meet applicable standards of manufacture, design and installation and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation;

C. Environmental Modifications must be compliant with applicable building codes.

DOCUMENTATION STANDARDS

A. The identified direct benefit or need must be documented within:

1. Service plan; and
2. Physician prescription and/or clinical evaluation as deemed appropriate; and

B. Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

1. Property owner of the residence where the requested modification is proposed;
2. Property owner's relationship to the individual;
3. What, if any, relationship the property owner has to the waiver program;
4. Length of time the individual has lived at this residence;
5. If a rental property - length of lease;
6. Written agreement of landlord for modification;
7. Verification of individual's intent to remain in the setting; and
8. Land survey may be required when exterior modification(s) approach property line.

C. Signed and approved RFA;

D. Signed and approved service plan;

E. Provider of services must maintain receipts for all incurred expenses related to the modification;

F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A lifetime cap of \$15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the \$15,000 lifetime cap, \$500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of activities not allowed include, but are not limited to the following, such as:

A. Adaptations or improvements which are not of direct medical or remedial benefit to the individual:

1. central heating and air conditioning;
2. routine home maintenance;
3. installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
4. roof repair;
5. structural repair;
6. garage doors;
7. elevators;
8. ceiling track lift systems;
9. driveways, decks, patios, sidewalks, household furnishings;
10. replacement of carpeting and other floor coverings;
11. storage (e.g., cabinets, shelving, closets), sheds;
12. swimming pools, spas or hot tubs;
13. video monitoring system;
14. adaptive switches or buttons to control devices intended for entertainment, employment, or education;
15. home security systems.

B. Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);

C. Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);

D. Modifications that will add square footage to the home;

E. Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);

G. Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);

H. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.

I. Services to participants receiving Adult Family Care.

J. Services to participants receiving Assisted Living.

• Environmental Modification services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/ DA approved Environmental Modification Individual
Agency	FSSA/ DA approved Environmental Modification Agency/ Contractor
Individual	Plumber
Individual	Architect

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual ▼

Provider Type:

FSSA/ DA approved Environmental Modification Individual

Provider Qualifications

License (specify):

Any applicable licensure must be in place

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes/ permits.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Agency ▼

Provider Type:

FSSA/ DA approved Environmental Modification Agency/ Contractor

Provider Qualifications

License (specify):

Any applicable licensure

IC 25-20.2 Home inspector

IC 25-28.5 Plumber

Certificate (specify):

IC 25-4 Architect

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval
 455 IAC 2 Provider qualifications: General requirements
 455 IAC 2 Maintenance of Records of services provided
 455 IAC 2 Liability insurance
 455 IAC 2 Professional qualifications and requirements; documentation of qualifications
 455 IAC 2 Warranty required
 Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual ▼

Provider Type:

Plumber

Provider Qualifications

License (specify):

IC 25-28.5

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual ▼

Provider Type:

Architect

Provider Qualifications

License (specify):

Certificate (specify):

IC 25-4

Other Standard (specify):

DA Approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and perm

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Health Care Coordination

HCBS Taxonomy:

Category 1:

Sub-Category 1:

05 Nursing

05020 skilled nursing

Category 2:

Sub-Category 2:

11 Other Health and Therapeutic Services

11010 health monitoring

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Health Care Coordination includes medical coordination provided by a Registered Nurse (RN) to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; delay/prevent deterioration of health status; management of chronic conditions; and/or improved health status. Health care coordination is open to any waiver

participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports.

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid Prior Authorization for skilled nursing services is not necessary prior to the provision of Health Care Coordination.

The appropriate level of Health Care Coordination service should be determined by a healthcare professional (RN, doctor).

ALLOWABLE ACTIVITIES

- Physician consults
- Medication ordering
- Development and oversight of a healthcare support plan

SERVICE STANDARDS

- Weekly consultations or reviews
- Face to face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the plan of care/CCB
- The provider of home health care coordination will provide a written report to pertinent parties at least quarterly. Pertinent parties includes the individual, guardian, waiver case manager, all service providers, and other entities.

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Current Indiana RN license for each nurse
- Evidence of a consultation including complete date and signature; consultation can be with the individual, other staff, other professionals, as well as health care professionals
- Evidence of a face-to-face visit with the individual, including complete date and signature

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Health care coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Health care coordination services are:

- a minimum of one (1) face to face visit per month
- not to exceed eight (8) hours of Health Care Coordination per month

ACTIVITIES NOT ALLOWED

- Skilled nursing services that are available under the Medicaid State plan
- Services to participants receiving Assisted Living waiver service
- Any other service otherwise provided by the waiver

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved physician practice

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health Care Coordination

Provider Category:

Agency ▼

Provider Type:

FSSA/DA approved physician practice

Provider Qualifications**License (specify):**

IC 25-23-1 RN

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

06 Home Delivered Meals

06010 home delivered meals ▼

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

A Home Delivered Meal is a nutritionally balanced meal. This service is essential in preventing institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health.

No more than two meals per day will be reimbursed under the waiver.

ALLOWABLE ACTIVITIES

- Provision of meals
- Diet/ nutrition counseling provided by a registered dietician
- Nutritional education
- Diet modification according to a physician's order as required meeting the individual's medical and nutritional needs

SERVICE STANDARDS

- Home Delivered Meals services must follow a written service plan addressing specific needs determined by the individual's assessment
- Home Delivered Meals will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home delivered meal is the most cost effective method of delivering a nutritionally adequate meal and it is not otherwise available through other funding sources.
- All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current servsafe certification.
- All home delivered meals provided must contain at least 1/3 of the current recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research council.

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Date of service and units of service documented

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- No more than two meals per day will be reimbursed under the waiver
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service
- Services to participants receiving Structured Family Caregiving waiver service

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Home Delivered Meals Agency


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency **Provider Type:**

FSSA/DA approved Home Delivered Meals Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Maintenance of records of services provided

Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging


Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutritional Supplements

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14032 supplies

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Service Definition *(Scope):*

Nutritional (Dietary) supplements include liquid supplements, such as "Boost" or "Ensure" to maintain an individual's health in order to remain in the community.

Supplements must be ordered by a physician, physician assistant, or nurse practitioner based on specific life stage, gender, and/ or lifestyle.

Reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local Area Agency on Aging (AAA) who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

- Enteral Formulae, category 1 such as "Boost" or "Ensure"

SERVICE STANDARDS

- Nutritional Supplement services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation to support services rendered

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An annual cap of \$1200 is available for nutritional supplement services.

ACTIVITIES NOT ALLOWED

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Nutritional Supplements Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Nutritional Supplements

Provider Category:

Agency

Provider Type:

FSSA/DA approved Nutritional Supplements Agency

Provider Qualifications

License *(specify):*

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Transfer of individual's record upon change of provider

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14010 personal emergency response system (PER)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

ALLOWABLE ACTIVITIES

- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision
- Device Installation service
- Ongoing monthly maintenance of device

SERVICE STANDARDS

- Personal Emergency Response services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation of expense for installation
- Documentation of monthly rental fee

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- The replacement cost of lost or damaged equipment
- Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety
- Services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Personal Emergency Response Sytem Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency ▼

Provider Type:

FSSA/ DA approved Personal Emergency Response Sytem Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements
 455 IAC 2 Maintenance of Records of services provided
 455 IAC 2 Liability insurance
 455 IAC 2 Professional qualifications and requirements; documentation of qualifications
 455 IAC 2 Warranty required
 Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pest Control

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services

17010 goods and services ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Reimbursement for approved Pest Control expenditures is reimbursed through the local Area Agency on Aging (AAA) who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

- Pest Control services are added to the service plan when the Case Manager determines-either through direct observation or client report- that a pest is present that is causing or is expected to cause more harm than is reasonable to accept

- Services to control pests are services that prevent, suppress, or eradicate pest infestation

SERVICE STANDARDS

- Pest control services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Receipts of specific service, date of service, and cost of service completed

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An annual cap of \$600 is available for pest control services.

ACTIVITIES NOT ALLOWED

- Pest Control services may not be used solely as a preventative measure, there must be documentation of a need for this service either through Care Manager direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept
- Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Pest Control Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pest Control

Provider Category:

Agency ▼

Provider Type:

FSSA/DA approved Pest Control Agency

Provider Qualifications

License *(specify):*

IC 15-3-3.6

Certificate *(specify):*

Other Standard *(specify):*

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14031 equipment and technology

Category 2:

Sub-Category 2:

17 Other Services

17020 interpreter ▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's service plan which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

A. Individuals requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA).

1. There should be no duplication of services between HCBS waiver and Medicaid State Plan;
2. The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
3. Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the

individual is limited to the Medicaid State Plan covered service/brand;

4. Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;

5. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

B. Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The request is the most cost effective or conservative means to meet the individual's specific need(s);
2. The request is individualized, specific, and consistent with, but not in excess of, the individual's need(s);

C. Requests will be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified need(s).

A. Communication Devices - computer adaptations for keyboard, picture boards, etc. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

B. Generators (portable) - when either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one (1) generator per individual per ten (10) year period;

C. Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision;

D. Self help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist;

E. Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

F. Manual wheelchairs - when required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

G. Maintenance - limited to \$500.00 annually for the repair and service of items that have been provided through a HCBS waiver:

1. Requests for service must detail parts cost and labor cost;
2. If the need for maintenance exceeds \$500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

H. Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

SERVICE STANDARDS

A. Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;

B. All items shall meet applicable standards of manufacture, design and service specifications;

DOCUMENTATION STANDARDS

Documentation standards include the following:

- A. The identified direct benefit or need must be documented within:
 - 1. POC/CCB; and
 - 2. Physician prescription and/or clinical evaluation as deemed appropriate.
- B. Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;
- C. Signed and approved Request for Approval to Authorize Services (RFA);
- D. Signed and approved POC/CCB;
- E. Provider of services must maintain receipts for all incurred expenses related to this service;
- F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maintenance - limited to \$500.00 annually for the repair and service of items that have been provided through a HCBS waiver:

- 1. Requests for service must detail parts cost and labor cost;
- 2. If the need for maintenance exceeds \$500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

ACTIVITIES NOT ALLOWED

- A. The following items and equipment:
 - 1. hospital beds, air fluidized suspension mattresses/beds;
 - 2. therapy mats;
 - 3. parallel bars;
 - 4. scales;
 - 5. activity streamers;
 - 6. paraffin machines or baths;
 - 7. therapy balls;
 - 8. books, games, toys;
 - 9. electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
 - 10. computers and software;
 - 11. adaptive switches and buttons;
 - 12. exercise equipment such as treadmills or exercise bikes;
 - 13. furniture;
 - 14. appliances - such as refrigerator, stove, hot water heater;
 - 15. indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
 - 16. swimming pools, spas, hot tubs, portable whirlpool pumps;
 - 17. temperpedic mattresses, positioning devices, pillows;
 - 18. bathtub lifts;
 - 19. motorized scooters;
 - 20. barrier creams, lotions, personal cleaning cloths;
 - 21. totally enclosed cribs and barred enclosures used for restraint purposes;
 - 22. Vehicle modifications.

B. Any equipment or items that can be authorized through Medicaid State Plan;

C. Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Specialized Medical Equipment and Supplies Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency ▼

Provider Type:

FSSA/ DA approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications

License (specify):

IC 25-26-21

Certificate (specify):

IC 6-2.5-8-1

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency ▼

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (specify):

IC 16-27-1

Certificate (specify):

Other Standard (*specify*):

DA approved

455 IAC 2-18 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02023 shared living, other

Category 2:

Sub-Category 2:

02 Round-the-Clock Services

02033 in-home round-the-clock services, other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (*Scope*):

Structured Family Caregiving means a living arrangement in which a participant lives in their private home or the private home of a principal caregiver who may be a non-family member or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of Structured Family Caregiving. Only agencies may be Structured Family Caregiving providers, with the Structured Family Caregiving settings being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by a registered nurse and one by a Structured Family Caregiving Home Manager. The provider agency must keep electronic daily notes.

The goal of this service is to provide necessary care while emphasizing the participant's independence. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participants HCBS Medicaid Waiver case manager and the Structured Family Caregiving provider. Participant

needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility level of care and whose needs can be met in a SFC setting.

Another goal is to preserve the dignity, self-respect and privacy of the participant by ensuring high-quality care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as the needs of the participant change.

ALLOWABLE ACTIVITIES

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services
- Medication oversight (to the extent permitted under State law)
- Transportation for necessary appointments that include transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Respite for the family caregiver (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem)
- Assistance with correspondence and bill paying if requested by the participant
- Other appropriate supports as described in the individuals service plan

SERVICE STANDARDS

- Structured family caregiving must be reflected in the participant's service plan
- Services must address the participant's level of service needs

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Requires completed Adult Family Care Level of Service Evaluation form. (Case manager must give the completed Adult Family Care Level of Service Evaluation form to the provider)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Structured Family Caregiving service will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed nurse or other health professional.
- Separate payment will not be made for Homemaker, Respite, Transportation, Personal Emergency Response System, Attendant Care, Assisted Living, Home Delivered Meals, Health Care Coordination or Adult Family Care as these activities are integral to and inherent in the provision of structured family caregiving services.

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Structured Family Caregiving Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Structured Family Caregiving

Provider Category:Agency **Provider Type:**

FSSA/DA approved Structured Family Caregiving Agency

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards.

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval
 455 IAC 2 Provider Qualifications: General Requirements
 455 IAC 2 General requirements for direct care staff
 455 IAC 2 Procedures for protecting individuals
 455 IAC 2 Unusual occurrence; reporting
 455 IAC 2 Transfer of individual's record upon change of provider
 455 IAC 2 Notice of termination of services
 455 IAC 2 Provider organizational chart
 455 IAC 2 Collaboration and quality control
 455 IAC 2 Data collection and reporting standards
 455 IAC 2 Quality assurance and quality improvement system
 455 IAC 2 Financial information
 455 IAC 2 Liability insurance
 455 IAC 2 Transportation of an individual
 455 IAC 2 Documentation of qualifications
 455 IAC 2 Maintenance of personnel records
 455 IAC 2 Adoption of personnel policies
 455 IAC 2 Operations manual
 455 IAC 2 Maintenance of records of services provided
 455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging


Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

15 Non-Medical Transportation

15010 non-medical transportation ▼

Category 2:**Sub-Category 2:**

▼

Category 3:**Sub-Category 3:**

▼

Category 4:**Sub-Category 4:**

▼

Service Definition (Scope):

Services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan

SERVICE STANDARDS

- Transportation services must follow a written service plan addressing specific needs determined by the individual's assessment
- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized

Transportation services are reimbursed at three (3) types of service:

1. Level 1 Transportation - the individual does not require mechanical assistance to transfer in and out of the vehicle
2. Level 2 Transportation - the individual requires mechanical assistance to transfer into and out of the vehicle
3. Adult Day Service Transportation - the individual requires round trip transportation to access adult day services

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 455 IAC 2

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

ACTIVITIES NOT ALLOWED

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Transportation Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency ▼

Provider Type:

FSSA/DA approved Transportation Agency

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

DA approved

- 455 IAC 2 Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider Qualifications: General Requirements
- 455 IAC 2 Procedures for protecting individuals
- 455 IAC 2 Unusual occurrence; reporting
- 455 IAC 2 Transfer of individual's record upon change of provider
- 455 IAC 2 Notice of termination of services
- 455 IAC 2 Provider organizational chart
- 455 IAC 2 Collaboration and quality control
- 455 IAC 2 Data collection and reporting standards
- 455 IAC 2 Quality assurance and quality improvement system
- 455 IAC 2 Financial information
- 455 IAC 2 Liability insurance
- 455 IAC 2 Transportation of an individual
- 455 IAC 2 Documentation of qualifications
- 455 IAC 2 Maintenance of personnel records
- 455 IAC 2 Adoption of personnel policies
- 455 IAC 2 Operations manual
- 455 IAC 2 Maintenance of records of services provided

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency ▾

Provider Type:

Licensed Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

Certificate (specify):

Other Standard (specify):

DA approved

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptation

Category 2:**Sub-Category 2:**
 ▾
Category 3:**Sub-Category 3:**
 ▾
Category 4:**Sub-Category 4:**
 ▾
Service Definition (Scope):

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in

the service plan, may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services.

The vehicle to be modified must meet all of the following:

1. The individual or primary caregiver is the titled owner;
2. The vehicle is registered and/or licensed under state law;
3. The vehicle has appropriate insurance as required by state law;
4. The vehicle is the individual's sole or primary means of transportation;
5. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.

All vehicle modifications must be approved by the waiver program prior to services being rendered.

A. Vehicle modification requests must meet and abide by the following:

1. The vehicle modification is based on, and designed to meet, the individual's specific need(s);
2. Only one vehicle per an individual's household may be modified;
3. The vehicle is less than ten (10) years old and has less than 100,000 miles on the odometer;
4. If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.

B. All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The modification is the most cost effective or conservative means to meet the individual's specific need(s);
2. The modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
3. All bids must be itemized.

C. Many automobile manufacturers offer a rebate of up to \$1,000.00 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

D. Requests for modifications may be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need(s).

A. Wheelchair lifts;

B. Wheelchair tie-downs (if not included with lift);

C. Wheelchair/scooter hoist;

D. Wheelchair/scooter carrier for roof or back of vehicle;

E. Raised roof and raised door openings;

F. Power transfer seat base (Excludes mobility base);

G. Maintenance is limited to \$500.00 annually for repair and service of items that have been funded through a HCBS waiver:

1. Requests for service must differentiate between parts and labor costs;
2. If the need for maintenance exceeds \$500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

H. Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

SERVICE STANDARDS

- A. Vehicle Modification must be of direct medical or remedial benefit to the individual;
- B. All items must meet applicable manufacturer, design and service standards.

DOCUMENTATION STANDARDS

- A. The identified direct benefit or need must be documented within:
 - 1. service plan; and
 - 2. Physician prescription and/or clinical evaluation as deemed appropriate.
- B. Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:
 - 1. ownership of vehicle to be modified; or
 - 2. vehicle owner's relationship to the individual; and
 - 3. make, model, mileage, and year of vehicle to be modified.
- C. Signed and approved RFA;
- D. Signed and approved service plan;
- E. Provider of services must maintain receipts for all incurred expenses related to the modification;
- F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A lifetime cap of \$15,000.00 is available for vehicle modifications. In addition to the applicable lifetime cap, \$500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

- A. Lowered floor van conversions;
- B. Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices;
- C. Repair or replacement of modified equipment damaged or destroyed in an accident;
- D. Alarm systems;
- E. Auto loan payments;
- F. Insurance coverage;
- G. Drivers license, title registration, or license plates;
- H. Emergency road service;
- I. Routine maintenance and repairs related to the vehicle itself.
- J. Services to participants receiving Adult Family Care waiver service.
- K. Services to participants receiving Assisted Living waiver service.

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

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Provider Category	Provider Type Title
Agency	FSSA/ DA approved Vehicle Modification Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency ▼

Provider Type:

FSSA/ DA approved Vehicle Modification Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Maintenance of records of services provided

455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.

☐ **As an administrative activity.** Complete item C-1-c.

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:




Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ No. Criminal history and/or background investigations are not required.
☒ Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All direct care providers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. Additionally, Licensed professionals are checked for findings through the Indiana Professional Licensing Agency. The Division of Aging also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 2-15-2 Adoption of personnel policies, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to individuals receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency verifying that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

Criminal history checks are maintained in agency files and are available upon request.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☐ No. The State does not conduct abuse registry screening.
☒ Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to Indiana Administrative Code 455 IAC 2.6.2 General Requirements: the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

Nurse aide registry documents are maintained in agency files and are available upon request.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

☐ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

☒ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Indiana State Licensed Residential Care Facilities	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

To maintain the integrity of a community based setting, personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. Individuals may choose to utilize their own furnishings. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect. While some assisted living facilities are located on the campus of or adjacent to a nursing facility, they are not located on the grounds of or immediately adjacent to a public institution.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Indiana State Licensed Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Modification Assessment	<input type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Structured Family Caregiving	<input type="checkbox"/>
Adult Day Service	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Personal Emergency Response System	

	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Case Management	<input checked="" type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Health Care Coordination	<input type="checkbox"/>
Assisted Living	<input checked="" type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Pest Control	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>

Facility Capacity Limit:

no limit

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☐ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☒ **Other policy.**

Specify:

Attendant Care, Case Management, Homemaker, Respite, and Adult Family Care waiver services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.

Relatives who receive payment for waiver services will be subject to post-payment review as described in

Appendix D-1-g and service plan monitoring as described in Appendix D-2-a. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant.

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The State Medicaid Agency's Office of Medicaid Policy and Planning and the Division of Aging are dedicated to increasing home and community-based providers for the waiver. The Division of Aging is promoting home and community-based services by using new marketing tools and personal visits to potential providers. The Division of Aging is dedicated to focusing on recruitment, certification, timely enrollment of providers by the fiscal agent contractor, and retention of waiver providers. Information regarding home and community-based services is posted on the Family and Social Services Administration's website. The Division of Aging has open enrollment meaning any provider can apply at any time.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C.1 Number and percent of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled licensed providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DA's Provider Relations Tracking Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.2 Number and percent of existing enrolled licensed providers that continue to meet provider qualifications. Numerator: Number of existing enrolled licensed providers continuing to meet provider qualifications. Denominator: Number of existing enrolled licensed enrolled waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Indiana State Department of Health (ISDH) Notice

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver*

requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C.3 Number and percent of newly enrolled non-licensed / non-certified providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled non-licensed / non-certified providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled non-licensed / non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DA's Provider Relations Tracking Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data	Frequency of data aggregation and

aggregation and analysis (check each that applies):	analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

C.4 Number and percent of non-licensed/non-certified providers that continue to meet waiver requirements. Numerator: Number of existing non-licensed/non-certified providers reviewed that continue to meet waiver requirements.

Denominator: Number of existing non-licensed/non-certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DA's Provider Compliance Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% over a 3 year period
	<input type="checkbox"/> Other	

	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C.5 Number and percent of newly enrolled case managers who completed initial case management training. Numerator: Number of newly enrolled case managers who completed initial case management training. Denominator: Number of newly enrolled case managers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Relations Training Record

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.6 Number and percent of case management providers who continue to meet training requirements. Numerator: Number of case management providers who meet training requirements. Denominator: Number case management providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DA's Provider Compliance Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% review over a 3 year period
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.7 Number and percent of providers who meet staff training requirements.**Numerator:** Number of providers who meet staff training requirements.**Denominator:** Total number of providers reviewed.**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

DA's Provider Compliance Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% review over a 3 year period
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other
Specify:
<div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The Division of Aging QA/QI Unit reviews daily incident reports, complaints, and other data sources, such as Adult Protective Services records, to determine on an on-going basis if specific provider trends exist. Additionally, the DA utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA QA/QI unit to determine if the problem or issue has been resolved.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- Various discovery activities conducted by the Division of Aging (DA) may lead to the identification of areas of non-compliance with the waiver provider agreement. The DA utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA QA/QI unit to determine if the problem or issue has been resolved. If existing documentation does not indicate resolution, QA/QI unit personnel initiate corrective actions. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as verifying that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations more formal actions may be taken. This may consist of a written corrective action plan (CAP), or a referral to the State Department of Health. The QA/QI unit is responsible for verifying that corrective actions are completed. Any provider decertified as a result of non-compliance with the provider agreement, and/or failing to complete corrective actions, will be notified of the decision, and of their right to appeal. Documentation of all corrective actions taken with providers will be maintained in the operating agency's Provider Database. Prior to taking action to suspend or terminate a provider alternative service options will be provided to any affected participants through their case manager.

C.1 and C.3: Indiana requires all new waiver provider-applicants to submit documentation verifying that they meet the criteria and qualifications to provide services prior to allowing them to enroll with the fiscal intermediary (FI). The process in place effectively prevents provider-applicants from providing waiver services prior to approval and enrollment. In the event a provider became enrolled and initiated delivery of waiver services prior to approval by the DA, the DA would instruct the fiscal intermediary (FI) to deny any claim relating to waiver service provision, and disenroll the provider-applicant until such time as provider-applicant fully documents they meet all qualifications. The DA will initiate an investigation of both internal and FI processes to identify deficiencies or vulnerabilities within the enrollment and approval processes and undertake appropriate improvements.

C.2 and C.4: To assure existing providers continue to meet provider qualifications, providers undergo a formal service review at least every three (3) years. For licensed providers, this review is conducted by the Indiana State Department of Health (ISDH). Non-licensed providers are reviewed by the operating agency. Both ISDH and the operating agency have formal review and remediation procedures which utilize CAPs submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to re-submit the CAP. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing the remediation process to document qualifications is decertified as a provider.

C.5: The DA requires all new waiver case managers to undergo training conducted by State personnel prior to being entered into the electronic case management database system as an approved provider of case management services. In the event a case manager (CM) is identified as providing services prior to completing the required training, the operating agency will instruct the FI to deny any claim for services and disenroll that individual as a provider of case management services. The CM-applicant will be required to complete the required training before being re-enrolled. The DA will implement an investigation of internal and FI practices to identify

deficiencies or vulnerabilities in the enrollment and approval processes and undertake improvements. The DA will also initiate formal complaint proceedings against the case manager's sponsoring provider agency, if applicable, with possible formal sanctions up to and including termination as a waiver provider.

C.6: To assure a high level of service delivery by case managers (CMs), service reviews are conducted on all case management entities DA's QA team. This review includes verification of documentation of individual CM training. Any finding of non-compliance with training requirements will result in formal remediation utilizing a CAP, submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two-week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to meet case manager training requirements is decertified as a CM provider.

C.7: To assure service delivery standards are met by provider personnel, service reviews are conducted on approved waiver providers by the DA's QA team. Included in each participant's service review is verification of documentation of training of each individual caregiver or service delivery personnel as required in the provider agreement. Any finding of non-compliance with training requirements will result in a formal remediation process utilizing a CAP submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two-week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to assure required personnel training is decertified as a provider.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ☒ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ☐ **Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

*****Current Amendment*****

Indiana's STP does not have final approval as of the date of this amendment. Version 6 of the STP was submitted to CMS on 3/30/2017 for final approval. Once Indiana's STP receives final approval, the State will update this section at next amendment/renewal. All settings will be in full compliance with 42 CFR 441.301(c)(4)-(5) by March 2019.

2016 language---

Indiana is not adding a new waiver but amending their current waiver and has an STP that details all steps to come into full compliance with 42 CFR 441.301(c)(4)-(5) by March 2019.

Per CMS guidance, the site specific assessment results to determine compliance of residential and non-residential settings was due by July 31, 2016.

Upon completion of the assessments, the State will update the STP. If the A&D waiver is amended in that time, under CMS direction and the assumption that Indiana will have an approved STP, Indiana will include this section at that time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the State**
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐ **Licensed physician (M.D. or D.O)**
☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager works closely with the participant, or the participant's legal guardian, and other persons the participant chooses to include in the service plan development process. The participant or legal guardian has sole authority to determine who is included in the service plan development process. The participant is provided with a "pick-list" of all approved service providers in his or her area and has freedom of choice to select among these providers for each service addressed in the service plan. The case manager encourages the participant to actively self-advocate by communicating needs and preferences to potential and selected providers and other plan development participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Persons involved in the service plan development are the participant or the participant's legal guardian, and other persons the participant chooses to include and the case manager. The case manager, in collaboration with the participant, develops the service plan and submits it to the DA for approval.

The case manager informs the individual of the services available under the waiver. The individual will be provided with a pick list of all Medicaid Waiver approved providers in the individual's geographic area that provide home and community-based services. It is the individual's choice to choose their services and service providers to meet their identified medical needs and goals.

The case manager in collaboration with the individual and providers completes initial, ninety (90) day, and annual re-determination assessments to evaluate the individual's strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Assessments can be conducted more often if needed. Based on the outcomes of the assessments, a comprehensive service plan is developed. The case manager assures the service plan meets the medical needs and goals of the individual and includes the individual's preferences of services, if available through the waiver, and assigns specific responsibilities for completion of the various components of the plan. The Service Plan is signed by the case manager and the individual or the individual's legal guardian. The DA waiver specialist provides a second level of review of the service plan to assure that the participant's goals, needs (including healthcare needs), and preferences

are met.

The individual signs a release form that allows the case manager to contact service providers once the client has selected the providers of choice. The case manager is responsible for the coordination of all services and to assure that needs are met. The case manager is responsible for the implementation and monitoring of the service plan.

The participant receives a copy of the service plan so they are aware of the services that are being provided and the frequency of the services by the service providers. The service plan development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the service plan by input from the participant, case manager, physician, provider of service, and the DA.

The case manager is required to conduct a face-to-face visit with the participant at least every ninety (90) days to ensure the health and welfare of the participant and to determine if the previously approved services continue to meet the medical needs and goals of the waiver participant. The service plan is also reviewed every ninety (90) days, or more often as necessary. Updates to the service plan can be made as often as necessary to reflect the participant's medical needs and goals.

All individuals must be Medicaid eligible prior to receiving waiver services, therefore, the State does not use temporary or interim service plans to get services initiated until a more detailed service plan can be finalized.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed both during the LOC and service planning processes. During the initial and renewal LOC processes, the Eligibility Screen tool is used to identify potential risks and vulnerabilities. Service plan development takes into account risks identified from the 90 Day Review assessments, which is used to develop the initial service plan and then at least every ninety (90) days thereafter. Appropriate interventions may be initiated immediately through the usual service system to address emergent needs.

Formal and informal back-up supports are identified early in the service planning process to address contingencies which could pose a threat to the participant's health or welfare. These contingency plans may address medical emergencies, failure of a support worker to appear when scheduled, or any other potential risk which can be identified by assessment tools, the participant, or members of their support system. Informal supports including friends, family, and neighbors may be used to assist in providing services in a crisis situation. The State also requires that all participants have easy access to emergency contact information and monitors for this in provider compliance reviews.

The State recognizes that risk tolerance varies greatly from participant to participant and encourages case managers to recognize and respect the participant's individual desires and preferences when formulating risk mitigation strategies.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As a service is identified, a pick list of approved Medicaid Waiver providers is generated in randomized sequence and is presented to the participant by the case manager. Participants and family members are encouraged to interview potential service providers and make their own choice. If the participant or parent/guardian wishes to select a provider that is not an approved waiver service provider, FSSA's Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) will assist in reviewing and processing applications from potential providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

FSSA has designated the Office of Medicaid Policy and Planning (OMPP) as the division under the single state agency that will retain responsibility for service plan approvals made by the Division of Aging (DA).

As part of its routine operations, DA will review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment, including physical health issues.

OMPP does not review and approve 100% of the service plans developed on this waiver. OMPP and DA will meet and review a service plan together when a situation arises suggesting the health and welfare of a waiver participant may be in question.

The OMPP will review and approve the policies, processes and standards for developing and approving waiver service plans. Based on the terms and conditions of this waiver, the Medicaid agency may review and overrule the approval or disapproval of any specific service plan acted upon by the DA serving in its capacity as the operating agency for this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☐ Every twelve months or more frequently when necessary
- ☒ Other schedule

Specify the other schedule:

Every ninety days or more frequently when necessary.

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency
- ☒ Operating agency
- ☒ Case manager
- ☐ Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The waiver case manager is the entity responsible for monitoring implementation of the service plan as well as the general health and welfare of the participant. The state requires the case manager to meet face-to-face with the participant at a minimum of every ninety (90) days. At this 90 Day Review, the case manager completes the 90 Day

assessments to assure that approved services continue to meet the medical needs and goals of the participant. The 90-Day assessments are comprehensive assessment tools which addresses the following domains via responses from both the case manager and the participant: service plan implementation and applicability, behavior, rights, medical issues, medication issues, seizures, nutrition and dining, health and safety, critical incident reporting and resolution, staffing, and financial issues. This review tool also provides a means of assessing the potential for suspected abuse, neglect or exploitation and forms the basis for any needed revision to the service plan.

All providers rendering services to the participant are required to coordinate efforts and to share documentation regarding the participant's well-being with the case manager. Providers of waiver services are required to have back-up plans to provide staffing for waiver participant's needs. At the ninety (90) Day Review, the case manager verifies with the participant the appropriateness and effectiveness of back up plans and adjusts the plan accordingly.

As part of the monitoring of the participant's health and welfare, the provider is required to send all incident reports to both the Division of Aging (DA) and the case manager. If follow-up is required for an incident, the State requires the case manager to provide follow-up every 7 days until the incident is deemed resolved. Similarly, the State may require the case manager to address any provider complaints filed by the participant, or on their behalf.

If changes to the service plan are warranted in order to meet the medical needs and goals of the participant, the case manager submits additional information and an updated service plan to the DA's Waiver Operations Unit. The DA's waiver specialist determines if the additional services are appropriate based on the assessment and documentation provided.

The case manager serves as the primary contact for the participant and family and is expected to coordinate needs with the participant's providers.

DA reviews service plan delivery and the supporting documentation through the use of the Person-Centered Compliance and Satisfaction Tool (PCCST).

Additional methods for systemic collection of information about monitoring results are detailed in Appendix H.

b. Monitoring Safeguards. *Select one:*

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D.1 Number and percent of participants' service plans that address participants' assessed needs and personal goals. Numerator: Number of participants' service plans that address participants' assessed needs and personal goals. Denominator: Number of service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.1 Electronic Case Management Database System - 90 Day Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.1 Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that	Sampling Approach (check each that applies):

<i>(check each that applies):</i>	<i>applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based on each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and

procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D.2 Number and percent of participants' service plans that were developed in accordance with State policies and procedures. Numerator: Number of participants' service plans that were developed in accordance with State policies and procedures. Denominator: Number of service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D.3 Number and percent of participant's service plans which were updated/revised within 12 months of the previous annual service plan. Numerator: Number of participant's service plans which were updated/revised within 12 months of the previous annual service plan. Denominator: Number of annual service plans due within the previous 12 month period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

D.4 Number and percent of participant's service plans which were updated/revised when warranted by changes in the waiver participant's needs. Numerator: Number of participant's service plans which were updated/revised when warranted by changes in the waiver participant's needs. Denominator: Number of service plans that identify a change in need.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation (check each that applies):	collection/generation (check each that applies):	<i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D.5 Number and percent of participants receiving services in accordance with the service plan. Numerator: Number of participants receiving services in accordance with the service plan. Denominator: Number of service plans reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5a Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5b Person Centered Compliance Tool (PCCT)

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):

collection/generation (check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based on each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. **Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.****Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D.6 Number and percent of participants that are afforded choice between/among waiver services and institutional care. Numerator: Number of participant's service plans with a signed Freedom of Choice form indicating the choice between waiver services and institutional care. Denominator: Number of participant service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.6a Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.6b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div><div></div><div></div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based on each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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Performance Measure:

D.7 Number and percent of participants that are afforded choice between/among waiver services and providers. Numerator: Number of participant's service plans with a signed Freedom of Choice form indicating the choice between/among waiver services and providers. Denominator: Number of service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.7a Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.7b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based on each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Discovery activities specific to each performance measure are carried out on an on-going basis by the Division of Aging (DA) QA/QI unit using electronic reports which gather data from each participant's individual electronic case management record, including the Service Plan and 90 Day Review. As individual service plan problems are identified through discovery processes, the DA will require corrective measures of the case manager or service provider, as appropriate, to assure the problem is resolved. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP), or a referral as a formal complaint to the DA which can result in sanctions up to and including termination as a provider. The DA will monitor implementation of corrective measures to verify resolution. As a safeguard against interruption of services, an extension service plan will be generated when necessary to continue services. If a participant's services are directly impacted by the suspension or termination of a provider, the case manager will be directed to assist the participant in choosing a new provider and the operating agency will assist in expediting this change.

D.1: Identification of an individual service plan which does not meet a participant's assessed needs and personal goals will result in a review of casenotes to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the waiver case manager (CM) and require an updated assessment or development of compliant service plan, as appropriate, recognizing the individual participant's choice of services and providers, and who to include in service planning. Failure by the CM to address the unmet need(s) may result in referral to the DA for handling as a formal complaint.

D.2, D.3, D.4, D.6 and D.7: Identification of a service plan for which evidence indicates that the plan was not developed in accordance with State policies and procedures will result in a review of casenotes, timelines and signatures to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the CM to determine steps needed to restore compliance. Potential areas of non-compliance for these measures include: timeliness; signatures indicating Freedom of Choice of providers and institution/waiver not in place; overdue 90 Day Review at time of plan submission; signatures of participant or legal guardian, or Case Manager missing; and not updating or revising the service plan to reflect a change in need. The required resolution will be completion of a revised or new service plan by the participant's CM. Findings of late service plan submission will be tracked to identify area or CM-specific trends, or other systemic issues. A case manager who does not adequately address a non-compliant issue, or who is found to have recurrent negative findings, will be referred to the DA for handling as a formal complaint.

D.5: Identification of a participant for whom services are not being delivered in accordance with the service plan will result in a review of casenotes, incident reports and other available documentation to determine the cause and circumstance of the finding. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the waiver case manager to determine steps needed to obtain compliance. Findings and remediations for this measure vary greatly as participant choice, medical conditions or interventions, and innumerable life circumstances, such as a vacation or a change in residence, can prompt a negative response on the tool used for this measure. Remediation may involve interruption or termination of the service plan if the participant is unable to benefit from, or chooses not to receive, services. A negative finding may also reflect a provider service delivery or quality issue. If attempts to remediate a provider issue have not been successful, the case manager will be directed to discuss alternative providers with the participant, respecting the participant's right of choice in selecting or maintaining a provider. If evidence indicates that billing has occurred when services have not been delivered, the provider will be referred to FSSA Program Integrity for review. The provider may also be referred for handling as a formal complaint.

Performance measures D.1, D.5, D.6 and D.7 have a secondary data source derived from the Person Centered Compliance Tool (PCCT) administered by the QA contractor to a statistically significant sample population. When specific PCCT probes reveal negative findings, the QA reviewer implements a formal remediation process utilizing a CAP, submitted by the appropriate provider, with approval or denial by the Reviewer, under supervision of the DA. If a CAP is denied, the provider is required to re-submit the CAP. Once approved, the Reviewer verifies successful implementation of the CAP. Any provider not completing the required corrective action(s) is referred to the DA for handling as a formal complaint. The complaint process can result in sanctions up to and including termination as a waiver provider. Prior to termination any current participants will be assisted in securing services from other providers. Any provider who is decertified as a result

of failing to complete corrective actions will be notified of the decision, and of their right to appeal.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- ☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ☒ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Individuals residing in Indiana and receiving attendant care on the Aged & Disabled (A&D) Medicaid Waiver are offered the self-directed attendant care service. Participants are empowered to choose their own personal attendants. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and (if necessary) dismiss their own personal attendants. The individual directing care of his/her representative takes on all of the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving self-directed attendant care service include:

- An opportunity to exercise more self-control, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- Allows the participant the opportunity to arrange for services from more than one personal attendant or from a combination of agency based care and self-directed attendant care, depending on the individual's service plan.

Attendant care providers may be recruited, hired, trained, paid, and supervised under the authority of the individual, individual's parent(s), other person acting on the individual's behalf, or the (emancipated) individual, if the individual, parent, or person acting on the individual's behalf, chooses to self-direct the attendant care providers and assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider.

Attendant Care services are defined in Appendix C1/C3 Service Specifications.

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the plan of care and cost comparison budget of the participant; assess the individual for participation in the self-directed attendant care service; assist the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager is required to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change. The case manager is also required to reauthorize the participant in the self-directed attendant care service every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist & verify weekly face to face visits with the participant.

The Division of Aging also contracts with a fiscal intermediary whose responsibilities include serving as the payroll department; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers and case managers with monthly reports of spending on individual's behalf; and responding to all questions posed by the participant and the provider and state officials.

Self directed care providers are required to document the activities performed. Attendant care services are available to the participant self-directing their care which include personal care such as bathing (tub, shower); partial bath; oral hygiene; hair care; shaving; intact skin care; dressing; clipping hair; application of cosmetics; hand and foot care; mobility including proper body mechanics; transfers; ambulation; use of assistive devices; nutrition including feeding and preparation and clean-up of meals; elimination which consists of using bedpan, bedside commode, toilet; incontinence or involuntary care; and emptying urine collection and colostomy bags; assisting with correspondence and bill paying; escorting services which includes taking the participant to community activities that are therapeutic in nature or that assist with maintaining natural supports; safety services which include the use of the principles of health and safety in relation to self and client; identify and elimination of safety hazards; and practicing health protection cleanliness by appropriate techniques of hand washing; and waste disposal and household tasks.

Activities not allowed under the self-directed attendant care service include performing medical procedures; providing services to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse,

licensed physician, or other health professionals; services that are for the benefit of other household members which include running errands; cooking; completing laundry; and providing childcare. Medical services not allowed are those that must be performed by a licensed healthcare professional.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

- ☒ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☐ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☐ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☐ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

- d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☐ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☒ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Self-directed attendant care service is limited to attendant care services only. No other service can be self-directed by the participant.

The option to self-direct is presented to the client by the inclusion of the fiscal intermediary on the pick list of providers presented to clients in need of attendant care services. Once attendant care is determined to be the appropriate service, this list is generated by the case manager and then reviewed with the client. The client signs off

on their selection of a provider for their attendant services. If they are interested in self-direction, the case manager then evaluates the ability of the client to self-direct or if there is a representative that can direct their care on their behalf. The 90 Day Self Directed Attendant Care 90 Day Review Checklist, or assessment, is used to determine if a participant is able to self-direct attendant care.

The following questions are asked for the Self-Directed Attendant Care Enrollment Checklist:

- Participant is capable of performing the duties required of an employer.
- Participant accepts full responsibility for direction of his personal care and managing the hours that have been approved in the plan of care.
- Participant is prepared to hire, train, supervise, and dismiss (if needed) an employee who will perform the duties of his personal assistant.
- Participant understands he will be receiving an enrollment packet from the Fiscal intermediary and will need to complete all necessary paperwork required to become an employer.
- Participant understands his employee(s) will need to complete the necessary paperwork provided by the Fiscal Intermediary before starting work.
- Participant understands the process of reporting the time his personal attendant has worked and understands the program's timekeeping procedures.
- Participant is aware that his personal attendant cannot provide more than 40 hours of service in a one-week period and will arrange for service from another attendant if he requires additional services.
- Participant is aware that if he has a spend-down, the spend-down requirement must be met before the attendant(s) can be paid.
- Participant is aware he must inform the Fiscal Intermediary of any changes of employment.
- Participant has developed a written back-up plan.
- Participant has identified emergency information which will be available to the personal attendant.
- Participant understands he is responsible for addressing any quality of care issues directly with his provider.
- Participant is aware of how to report abuse or fraud promptly to the specified authorities and to the case manager.
- Participant understands that the case manager will be checking in at 90-day intervals and will file an incident report to the State to report any quality-of-care issues or lapses in employer responsibilities.
- Participant understands that if these issues are not resolved that the case manager can revoke eligibility for the self-directed care program.
- Participant understands he will be required to address Incident Report Issues when investigated by the State.
- Participant further understands that failure to do so may result in termination from the self-directed care program.
- Participant is aware of the customer Service Hotline and how to contact it.

The following questions are asked for the 90 Day Self-Directed Attendant Care 90 Day Review Checklist:

- Participant or his representative continues to be capable of performing the duties required of an employer.
- The number of hours of care the provider has delivered is in line with the plan of care.
- No personal attendant has provided more than 40 hours of service in any given one-week period within the plan of care.
- Participant or representative has submitted timesheets and completed all necessary paperwork as requested by the fiscal intermediary.
- Participant or representative has hired, trained and is actively supervising the personal attendant(s).
- Participant or representative is able to address quality of care and or performance issues with the personal attendant(s).
- Provider is delivering all services appropriately as stated in the plan of care and as described in the Participant/Provider responsibilities worksheet.
- Participant has a written back-up plan. Back-up provider is still available to provide care.
- Emergency information is up to date and available to personal attendant(s).
- There are no issues of abuse, fraud, or neglect.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Individuals residing in Indiana and receiving attendant care on the Aged & Disabled (A&D) Medicaid Waiver are offered the self-directed attendant care service option. Participants are empowered to choose their own personal attendants. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and (if necessary) dismiss their own personal attendants. The individual, or the individual's representative, directing care takes on all of the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving self-directed attendant care service include:

- An opportunity to exercise more self-control, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- Allows the participant the opportunity to arrange for services from more than one personal attendant or from a combination of agency based care and self-directed attendant care, depending on the participant's service plan.
- The role of the case manager is to assess the individual for participation in the self-directed attendant care service; assist the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager is required to reauthorize the participant in the program every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist & verify weekly face to face visits with the participant.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ **The State does not provide for the direction of waiver services by a representative.**
- ☒ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ **Waiver services may be directed by a legal representative of the participant.**
- ☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Attendant care providers may be recruited, hired, trained, paid, and supervised under the authority of the individual, individual's parent(s), other person acting on the individual's behalf, or the emancipated individual, if the individual, parent, or person acting on the individual's behalf, chooses to self-direct the attendant care providers and assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider. Attendant Care services will not be reimbursed when provided by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the service plan for the participant. One of the case manager's responsibilities is to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist & verify weekly face to face visits with the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- ☒ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☐ **Governmental entities**

☒ **Private entities**

- ☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☐ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- ☒ **FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

As the operating agency, the Division of Aging through the procurement process, contracted with a fiscal intermediary for the self-directed attendant care service whose job responsibilities include serving as the payroll department; including administering limited criminal history background checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers, and case managers with monthly reports of fiscal intermediary spending on individual's behalf; and responding to questions and issues concerning the self-directed attendant care service.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The self-directed attendant care service fiscal intermediary is compensated for administrative activities which

include compensation for performing payroll and related functions for participants who are self-directing their care. The administrative activity costs are divided equally per month throughout the length of the contract. The fiscal intermediary is also reimbursed based upon an established fee for service for each quarter hour of attendant care services provided by the participant's provider of service on the approved service plan. The ratio between the administrative activities and the fee for service activities is 1-4 or 25% to 75%. Therefore, the administrative activities equal 25% percent of the total cost of the self-directed care program and the fee for service equals 75% of the cost of the self-directed attendant care service.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Division of Aging's Deputy Director, or designee, is responsible for monitoring the performance of the fiscal intermediary (detailed in Appendix E-1) through weekly telephonic conference calls and weekly written reports on payments to providers. The reports include the number of participants, the number of providers, dollar

amounts, and which participants have service plans but are not receiving services.

The DA's quality assurance contractor performs customer satisfaction surveys on a statistically valid sample of participants, including the participants enrolled in the self-directed attendant care services, to assure participant's service needs within the service plan are being met.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the service plan for the participant. One of the case manager's responsibilities is to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change.

The role of the case manager is to assess the individual for participation in the self-directed attendant care service; assists the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager also helps to provide administrative guidance to the individual, or the individual's representative, regarding the self-directed attendant care service implementation process which includes: training on the program via manual study or one of the forms of electronic information; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the self-directed attendant care personal attendant; direct the employer to the fiscal intermediary's Help Line if assistance is needed with the completion of the fiscal intermediary forms and paperwork; and monitoring the outcomes of the self-directed attendant care service, to the extent as agency services are monitored. The case manager is required to reauthorize the participant in the program every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist & verify weekly face to face visits with the participant.

If at any time the case manager identifies the health and welfare of the participant is beyond the scope of the self-directed attendant care service or identifies the participant, or participant's representative, is unable to fulfill the responsibilities as outlined in the self-directed attendant care service, other service options will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

- ☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Modification Assessment	<input type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Structured Family Caregiving	<input type="checkbox"/>
Adult Day Service	

	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Health Care Coordination	<input type="checkbox"/>
Assisted Living	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Pest Control	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>

- ☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If at any time the participant voluntarily chooses to terminate the self-directed attendant care service, the case manager will provide information regarding other service options and to assure continuity of services to meet the participant's needs. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist along with the case manager.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If at any time the case manager identifies the health and welfare of the participant is beyond the scope of the self-directed attendant care service or identifies the participant, or participant's representative, is unable to fulfill the responsibilities as outlined in the self-directed attendant care service, other service options will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. Individuals directing care on behalf of the participant will be required to sign the 90 Day Self Directed Attendant Care 90 Day Review Checklist along with the case manager. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1	375		
Year 2	375		
Year 3	375		
Year 4	375		
Year 5	375		

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer

(managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☒ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one:*

- ☐ Modifications to the participant directed budget must be preceded by a change in the service plan.
- ☐ The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The case manager's responsibilities include provision of both written and oral explanations of the participant's, or the guardian's-if appropriate, right to the Medicaid Fair Hearing process. This notification will occur at the time of initial assessment, reassessments and for any updates to the service plan related to participant's choice between institutional care and community based services, selection of services and service providers if community based care is chosen. This notification will include rights of appeal if services are suspended, denied, reduced or terminated.

The case manager maintains copies of all written notices and electronically filed documents related to an individual's level of care determination and the individual's right to a Medicaid Fair Hearing. The case manager must ensure that the Level of Care Review Form is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database system the date the Level of Care Review Form was sent to the applicant or participant.

The Notice of Action - State Form 46015 - HCBS5 - is used to notify each Medicaid applicant or participant of any action that affects the individual's Medicaid waiver benefits. An action may be a suspension, termination, reduction, or increase of all or any amount of covered services. This also includes actions taken to approve or deny new applicants. An explanation regarding a HCBS waiver service participant's appeal rights and the opportunity for a fair hearing is located on each Notice of Action. Part 2, "Your Right to Appeal and Have a Fair Hearing" advises individuals of their right to appeal and the timely actions which are required. Part 3, "How to Request an Appeal" provides instructions for individuals regarding the procedures that are necessary in the appeal process.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 33 days of the decision date noted on the Notice of Action.

Written materials will be maintained in the participant's information folder kept in the home. Additionally, written materials detailing the service plan and service providers are mailed to the participant to allow for a right to appeal the service delivery plan and right to a Medicaid Fair Hearing. This formal notice occurs after the initial service plan is developed and at time of renewal or at any time there is a change in the service plan.

The case manager maintains copies of all written notices and electronically filed documents related to an individual's service plan and the individual's right to a Medicaid Fair Hearing. The case manager must ensure that the Notice of Action is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database the date the Notice of Action was sent to the applicant or participant.

If an applicant is denied waiver services, a written Notice of Action is sent detailing the reasons for denial and explains the individual's right to appeal this decision and right to a Medicaid Fair Hearing. Written notice will be provided at least 10 days prior to a participant's waiver services being decreased, suspended or terminated. The written notice will detail the reasons for the decision and explain the individual's right to appeal this decision and right to a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
 - ☒ **No. This Appendix does not apply**
 - ☐ **Yes. The State operates an additional dispute resolution process**
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.




Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*
 - ☐ **No. This Appendix does not apply**

- ☒ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Division of Aging is responsible for managing complaints related to participants receiving services coordinated and administered by the DA.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DIVISION OF AGING GRIEVANCE/ COMPLAINT SYSTEM

The Grievance/Complaint System is not a pre-requisite or substitute for the Fair Hearing process.

A. TYPES OF GRIEVANCES/COMPLAINTS THAT PARTICIPANTS MAY REGISTER

DA accepts complaints from any person or entity, when such complaints are related to, participants receiving services that are coordinated and administered by the Division of Aging.

Complaints not specific to the DA are referred to the appropriate entity (agency/division/authority).

B. PROCESS AND TIMELINES FOR ADDRESSING GRIEVANCES/ COMPLAINTS

Complaints are acted upon by the QA/QI Unit in accordance with the nature of the complaint. Issues that immediately affect a participant's health and welfare are entered as incidents and classified as "Sentinel". This classification requires an immediate response and follow-up until the incident is resolved. A detailed description of resolution activities is provided in Appendix G-1d. An issue would be identified as a complaint only when there is not an immediate impact on the participant.

CRITICAL/Not Immediate - affecting participant's health and welfare; require a 4 day response time.

URGENT- serious problem, but not affecting participant's health and welfare; require a 7 day response time.

STANDARD- general complaint with no critical or urgent impact; require a 21 day response time.

Complaints will be resolved through

- direct contact/ interviews with the complainant, service provider and other entities, as necessary
- documentation review, as necessary
- on-site visit, if indicated
- referral to the case manager for follow up -including the participant freedom of choice to select other providers

C. MECHANISMS THAT ARE USED TO RESOLVE GRIEVANCES/ COMPLAINTS

Complaints may require specific action by the DA as required by State and Federal law, regulation or policy depending on the type of complaint.

Complaints concerning licensed providers' quality of care issues will be referred to the State Department of Health as appropriate within four (4) business days.

Complaints alleging fraudulent billings or falsified time records will be researched through claims management and referred to the Surveillance and Utilization Review (SUR) Unit, as appropriate, for follow-up or action within four (4) business days.

Systemic complaints may be referred to internal FSSA investigators or the Attorney General's office for consumer protection.

When there is not timely resolution; additional actions may be taken including:

- a request for a provider corrective action plan within two weeks
- a formal provider review within 30 days

- a hold (up to 60 days) on new referrals while corrective action/ formal review takes place
- termination of the provider agreement for non-compliance after 60 day notice

CLOSING THE GRIEVANCE/ COMPLAINT

The complaint will be closed by the QA/QI Unit when the participant's needs have been addressed. The participant (or individual filing the complaint on participant's behalf) will be notified in writing (or e-mail when available) of the resolution and closure.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana's 455 IAC 2 requires all providers of HCBS waiver services, including case managers, to submit incident reports to the DA when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of an HCBS participant.

Events which must be reported include, but are not limited to:

- Alleged, suspected, reported or observed abuse/battery, neglect, or exploitation of a participant.
- The unexpected death of a participant
- Significant injuries to the participant requiring emergent medical intervention
- Any threat or attempt of suicide made by the participant
- Any unusual hospitalization due to a significant change in health and/or mental status may require a change in service provision
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day setting
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity by a) provider's staff when it affects or has the potential to affect the participant's care; (b) a family member of a participant receiving services when it affects or has the potential to affect the participant's care or services; or (c) the participant receiving services;
- Police arrest of the participant or any person responsible for the care of the participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraints

All service providers, including case managers, with knowledge of an incident event are required to submit an incident report through the DA web-based Incident Reporting system. If web access is unavailable, incidents can be reported to the DA by telephone, e-mail or fax. Recent changes to the incident reporting system allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members and direct caregivers.

Additionally, 455 IAC 2 requires reporting of known or suspected abuse, neglect, or exploitation (A-N-E) of an adult to Adult Protective Services. A twenty-four (24) hour hot-line connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or County Prosecutor's office. A toll-free twenty-four (24) hour number is available through Indiana Department of Child Services (DCS) for reporting child abuse, neglect or exploitation.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of A-N-E of a participant, pending the provider's investigation of the incident. If needed, the case manager coordinates re-placement services for the participant. In the event that the case manager is the alleged perpetrator the participant will be given a new pick list from which a new case manager will be selected.

Providers of home and community-based services are required to submit an incident report for any reportable unusual occurrence within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of A-N-E, it is required to be submitted within twenty-four (24) hours of "first knowledge" of the incident.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As a part of the service plan process, participants, family members and/or legal guardians are advised by the case manager via written materials of the DA's abuse, neglect and exploitation reporting procedures. The case manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in service plan development. The age appropriate toll-free hotline number is written inside of the participant's packet of service information. This number is also inside the front cover of all telephone books in the state. This information will be reviewed formally at 90 day face-to-face updates and informally during monthly telephone contacts with the participant and/or guardian.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incidents are received by the DA via a secure web-based reporting system which links to the electronic incident database. DA's Incident reporting staff process the incidents within one (1) work day of receipt of the reports. Processing each report includes coding the incident by Type, Apparent Cause, Resources Utilized and when applicable, Perpetrator, sub-type(s), and Outcome. Reviewers also determine what level of follow-up is required, if any, and send notifications to the case manager, DA, and provider of specific required actions.

Required actions may include:

- notification of APS or CPS if the incident involves A-N-E and notification is not documented in the report;
- additional follow-up by the case manager when the incident has not been resolved;
- follow-up by the DA when it appears the participant is at risk of further A-N-E or other substantial threat of harm (sentinel status). This follow-up is expected to be made by DA personnel within 48 hours of notification;
- submission of a new report when the first report was inadequate or incomplete.

The incident reviewer also sends notifications to the case manager when follow-up is not required and to the DA informing of all A-N-E reports. Additional notifications may be sent to reporting entities and the DA when incident reporting requirements for timeliness are not met, or when the report should have been submitted by another party.

All incidents which are not resolved require case manager follow-up and reporting every seven (7) days until the incident is determined by the incident reviewer to be resolved. Follow-up reports are also submitted via the web-based incident reporting system.

Aggregated incident data is reviewed by the QA/QI Unit and the QA Committee to determine patterns which may result in required plan of corrections from providers, enhanced service provision for participants, or other modifications or enhancements to the waiver program.

The DA forwards geographic specific reports to each case management entity to aid them in tracking unresolved incident reports. Unresolved reports are monitored weekly by the DA.

All participants' deaths are required to be reported to the relevant APS unit or to the Department of Child Services (DCS) as applicable. APS units, DCS investigators and/or law enforcement conduct independent investigations of deaths and A-N-E reports at their discretion and following their departmental protocols.

Participant deaths are reviewed by the DA QA/QI unit along with any previously filed incident reports involving the participant. Additional information, including provider's records of service delivery, may be collected for further review of any unexpected deaths. If additional review is indicated it is referred for review by the Mortality Review Committee.

The Mortality Review Committee will review all deaths that involve the participant when:

- death is due to alleged, suspected or known abuse or neglect
- death is from trauma or accident
- death is alleged or known suicide or homicide
- death occurs unexpectedly following transition from a Nursing facility
- death occurs when participant has gone missing from normal care setting

The Mortality Review Committee may:

- request additional information and review the case a second time when the requested information is in the file;
- close a case with recommendations for the provider(s) or a case manager, a referral to another entity, or a systemic recommendation; or
- close a case with no recommendation(s).

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oversight of reporting and response to incidents is the direct responsibility of the Division of Aging. The web-based incident reporting system is augmented with e-mail tracking and "cc-ing" to DA's QA staff. QA staff are notified daily of all reports of A-N-E and death.

Additional reports track:

- "Non-resolved" Reports – generated weekly to DA QA staff with area-specific reports to the AAAs and independent case managers
- "Incidents by Type" report – reviewed by the QA/QI Committee
- "Sentinel Status" report – Identifies "not-resolved" and "days-to-resolve" A-N-E and other critical incidents – reviewed by the QA/QI Committee.
- Statewide and Area-specific Dashboard Reports identify number of total incidents, deaths, and A-N-E reports, with year-by-year comparisons. Reviewed on-demand and at each QA/QI Committee meeting

The QA/QI Committee reviews incident reporting data at each meeting. In addition to the DA QA Unit staff, the QA/QI Committee includes FSSA representatives, APS Program Director, and the Waiver Unit designee. Staff who initially review the web-based incident reports are also represented on the committee.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☒ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The DA prohibits the use of restraints or seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited restraint and/or seclusion usage by a provider is reported through the web-based incident reporting system.

The prohibition of use of seclusion and/or restraints including personal restraint, chemical restraint and/or mechanical restraint is included as a part of the required case manager training.

The Division of Aging has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of participant's care, the thirty (30) day follow up and the ninety (90) day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited restraint usage or seclusion of the participant.

- ☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- ☒ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The DA prohibits the use of restrictive interventions by its service providers regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the web based incident reporting procedure.

The prohibition of the use of restrictive interventions is included as a part of the required case managers' training.

The Division of Aging has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of participant's care, the thirty (30) day follow up by phone and the ninety (90) day face to face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of restrictive interventions of the participant to prevent reoccurrence.

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and

overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☒ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The DA prohibits the use of seclusion by its service providers regardless of the waiver setting. Reporting of prohibited usage of seclusion by a provider is reported through the web based incident reporting procedure.

The prohibition of the use of seclusion is included as a part of the required case managers' training.

The Division of Aging has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of participant's care, the thirty (30) day follow up by phone and the ninety (90) day face to face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of seclusion of the participant to prevent reoccurrence.

☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. **Applicability.** Select one:

- ☐ **No. This Appendix is not applicable** *(do not complete the remaining items)*
☒ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication management and follow up responsibilities resides with the approved waiver providers that provide twenty-four (24) hour services to the waiver participants. For the waiver, this includes the Assisted Living (AL) service, Adult Family Care (AFC) service, Structured Family Caregiving (SFC) and may include Adult Day Services (ADS) when participants have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. Additionally, medication administration / management is allowed only within the scope of the practice for the delivery of the medications. In Indiana, medication management and oversight may include reminders, cues, opening of medication containers or providing assistance to the participant who is competent, but otherwise unable to accomplish the task.

AL, ADS, AFC and SFC waiver providers must include in their waiver provider application the procedures and forms they will use to monitor and document medication consumption. These providers must also adhere to the DA rules and policies as well as the specific waiver definition which include activities that are allowed and not allowed, service standards, and documentation standards for each service. All providers must adhere to the DA's Incident Reporting (IR) policies and procedures related to unusual occurrences which includes medication errors. All approved waiver providers that are responsible for medication management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). Additionally, AL providers licensed by the Indiana State Department of Health (ISDH) must also report medication errors to the ISDH. Please refer to Appendix G1-b for specific details regarding the IR process.

For approved service providers, medication management means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications). The provider must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the participant and he/she requires assistance in the delivery of such medication. Additionally, the provider must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom of the home.

The case manager conducts a face-to-face visit with the participant at least every ninety (90) days to assure all services, including medication management, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the DA, or its designee, to assure compliance with all applicable rules and regulations.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Providers must demonstrate an understanding of each participant's medication regime which includes the reason for the medication, medication actions, specific instructions, and common side effects. The provider must maintain a written medication record for each participant for whom they assist with medication management. Medication records will be reviewed as a part of announced and unannounced provider visits and service reviews by case managers, DA staff or their contracted representatives. Any noncompliance issues or concerns are addressed promptly, including a corrective action plan as deemed necessary and appropriate.

Monitoring of medication management is included within the person centered compliance review process for participants selected for random review. Case managers review services, including medication management, during their 90 day participant service plan review. Additionally, other scheduled visits to participants using AL, AFC, ADS and SFC services are conducted by the QA Liaison staff.

DA and OMPP are responsible for monitoring and oversight of medication management practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider compliance review process, mortality review, and the complaint process. Data is analyzed at the individual level, the provider level, and the state level. The data allows for implementation of corrective action plans and could

lead to disciplinary measures up to and including provider de-certification.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☒ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy.

Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Indiana, medication management means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications). Waiver providers that are not licensed by ISDH are restricted to medication management services. Waiver providers licensed by ISDH must follow State regulations concerning the administration of medications. All providers must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the participant and he/she requires assistance in the delivery of such medication. Additionally, all providers must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom.

iii. Medication Error Reporting. *Select one of the following:*

- ☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

All approved waiver providers that are responsible for medication management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). AL waiver service providers must also report medication errors to the Indiana State Department of Health (ISDH).

(b) Specify the types of medication errors that providers are required to *record*:

AL waiver service providers, by ISDH regulation, 410 IAC 16.2-5-4(e)(7), are required to record any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication management are required to record medication errors in the participants' record as per DA's IR policy.

(c) Specify the types of medication errors that providers must *report* to the State:

For AL waiver providers, the facilities are required to report to ISDH any unusual occurrences which may include medication errors if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current ISDH policy on unusual occurrences includes the reporting of medication errors to ISDH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication management must report medication errors in accordance with the DA's

IR policy which includes errors of wrong medication, wrong dosage, missed dosage or wrong route.

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

	 
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- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

ISDH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, DA gathers data through incident reporting, complaints, provider surveys, and mortality review which is reviewed by the QA/QI committee. Identified problems with medication administration involving licensed waiver providers are referred to ISDH. The QA/QI committee reviews and reports medication administration error trends to the DA executive staff for further remedial action as deemed necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G.1 Number and percent of sentinel incidents, including abuse, neglect, and exploitation (A-N-E), that are monitored to appropriate resolution. Numerator: Number of sentinel incidents, including abuse, neglect, and exploitation (A-N-E), that are monitored to appropriate resolution. Denominator: Number of Sentinel Incidents reported.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Sentinel Resolution Report

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.2 Number and percent of participants that report they are free from abuse, neglect, and exploitation (A-N-E). Numerator: Number of participants that report they are free from abuse, neglect, and exploitation(A-N-E). Denominator: Number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

G.2a Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

G.2b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.3 Number and percent of active participants with 90 Day Reviews indicating primary care is being provided. Numerator: Number of participants indicating primary care was received in the previous 12 months as reflected in the 90 day review Denominator: Number of active participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

G.4 Number and percent of participants indicating their health care needs are being addressed. Numerator: Number of participants indicating their current health care needs are being addressed as reflected in the 90 Day Review. Denominator: Number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.5 Number and percent of participants whose acute health needs are addressed in a timely manner. Numerator: Number of participants whose acute health needs are addressed in a timely manner. Denominator: Number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was

		based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW B.1 Number and Percent of incidents that were reported within the required time periods. Numerator: Total number of incidents reported within the time periods. Denominator: Total number of incidents reported.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

HW B.2 Number and percent of incidents that were resolved within the stipulated time period. Numerator: Total number of incidents which were resolved within the stipulated time period. Denominator: Total number of incidents reported.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW C.1 Number and percent of reported uses of restraints that resulted in medical treatment. Numerator: Total number of reported uses of restraints that resulted in medical treatment. Denominator: Total number of reported uses of restraints.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW D.1 Number and percent of sentinel events regarding medication errors that resulted in medical treatment. Numerator: Total number of medication errors that resulted in medical treatment. Denominator: Total number of medication errors.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. In addition to incident reporting, filed complaints are reviewed to determine if trends exist involving specific providers. Reported provider complaints and provider related incidents are compared to APS data bases to determine systemic issues affecting participants and/or community in general.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the State to document these items.

DA staff becomes directly involved with any incident with sentinel status by following up with case managers, providers and participants as necessary. DA QA/QI Unit staff work directly with APS units to reach resolution and/or to determine next steps to safeguard participants at risk of abuse, neglect or exploitation.

An APS/QA Liaison staff person is responsible for coordination of response to high risk participants and/or settings through out the state by working directly with local APS units, local LTC Ombudsman, AAA, Case managers and other providers.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory

requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DISCOVERY and ANALYSIS

Initial analysis of discovery data is conducted by various DA program staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:

- Electronic Case Management Database queries - The DA utilizes several electronic case management database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide some of the performance measurement data for the waiver sub-assurances.
- Incident Review - The DA requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by incident review staff within one working day of receipt. "Processing" entails coding reports by type, designation of sentinel events, determining whether or not

follow-up is required, assuring that all events or allegations of abuse, neglect or exploitation are reported to APS or CPS appropriately, and directing notifications to involved entities. Follow-up reports, when required, are due from the case manager within 7 days of the processing date, at which time the review staff may close the incident or require additional follow-up. All reports of actual or alleged ANE are designated as sentinel events and forwarded to the DA for additional review in addition to the required submission to APS/CPS.

- **Mortality Review** - All incident reports of waiver participants' deaths are forwarded to the DA Quality Assurance team for review. Death events which may have been impacted by the provision or non-provision of waiver services are referred to designated Mortality Review staff for further investigation.
- **Complaints System** - The DA operates a complaint hot-line and all complaints are tracked and addressed by designated DA staff.
- **Person-Centered Compliance Tool (PCCT)** - A statistically valid random sample of waiver program participants is visited each year for the purpose of completing the PCCT. This service review tool is used to validate the receipt of appropriate services and determine the overall satisfaction the consumer has with delivered services, formal and informal supports, access to services and opportunities outside the home, and freedom from abuse, neglect and exploitation. The collection of this information involves a review of service documentation and staff training related to the subject participant, and if found deficient, will result in a corrective action plan (CAP) process for the provider. Meetings are held monthly with the QA team to discuss their on-site reviews and participant findings.
- **Provider Compliance Tool (PCT)** - The PCT review involves a service review visit to each non-licensed/non-certified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. Additional provider reviews may be authorized by DA administration as warranted by complaints, critical incidents, or other extenuating circumstances. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider. Meetings are held monthly with the QA to discuss their on-site reviews and provider findings.
- **QA Quarterly Report** - Provides aggregation, analysis and summarization of PCCT and PCT review findings conducted in the preceding quarter, along with remediation activities and results.
- **Indiana State Department of Health (ISDH) licensure monitoring** - The DA and ISDH work cooperatively to assure that licensed providers continue to meet all waiver requirements. Licensed providers are reviewed each year for a compliance review. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.

COMPILATION and TRENDING OF PERFORMANCE MEASURES

The DA and OMPP have identified key performance measures and present these in numerator/denominator format. These measures are derived from other discovery activities but serve as both discovery and analytical tools. Each of these measures corresponds with a sub-assurance identified in the waiver application.

Data obtained from all of these sources, as well as data generated through remediation processes, is disseminated to DA Quality Assurance Unit staff and is provided to the FSSA and QA/QI Committee for trend analysis and remediation of systemic issues. Remediation of individual findings is initiated immediately at the program and service level.

The QA/QI Committee is composed of DA QA/QI Unit staff, including the APS program director and liaison, and representatives from the FSSA, the incident processing staff, Case Management representative and the DA Waiver Unit. The QA/QI Committee will meet at least quarterly to review and evaluate the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares current performance to past or anticipated performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic deficiencies. The Committee also reviews reports and descriptions of best-practice quality improvement approaches from other states. QA/QI Committee recommendations for system improvements will be researched and developed into proposals by the Waiver QIS Work Group for consideration by the DA Management Group.

SYSTEM IMPROVEMENT and DESIGN

The DA Management Group includes upper management personnel from DA and FSSA, and may include legal representation. The group's role is to provide leadership and direction for quality improvement projects, policy revision or development, and actions leading to refinement of quality operations and system management.

Proposals for system improvements are considered by the DA Management Group. The Management Group may assign research, design or implementation activities back to QA staff, the Waiver QIS Work Group, other DA or FSSA personnel, or contracted entities.

Prioritization of system improvement activities will be subject to several factors:

- regulatory requirements as specified by law or funding sources;
- potential to reduce risk or negative outcomes for program participants;
- potential to effect positive outcomes for a substantial number of participants;
- potential for implementation success;
- cost and feasibility of implementation activities;
- ability to measure results and outcomes of system improvements;
- organizational will: Are the necessary system actors motivated to implement desired changes?

The Division of Aging and FSSA are sensitive to the complexities of the service delivery system and the profound impact that change can have on both that system and on the individuals we serve. While the scope of any given system improvement initiative will determine the implementation processes, when appropriate the state will;

- seek and consider stakeholder input;
- communicate changes and timelines to stakeholders, clearly identifying how the change may impact them;
- use beta testing and limited roll-out strategies;
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

Decisions regarding changes to the waiver program will be documented in meeting notes and minutes which will be distributed internally to FSSA, the DA Waiver Unit and the DA QA/QI Unit, as well as other members of the Management Group. The DA Waiver Unit will have primary responsibility for implementing changes as directed by the DA Management Group, and for communicating changes to stakeholders. Documentation of communication to external stakeholders will be maintained within the electronic case management database.

Outcomes of all system changes and improvements will be monitored using the discovery and analysis tools and process described above. Measures obtained from these tools and processes will be compared to past and anticipated measures in continuation of the quality improvement cycle.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The DA utilizes several electronic case management database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow the DA QA/QI Unit to monitor and assess the outcome and effects of system design changes.

The DA and FSSA have identified key performance measures which are compiled in numerator / denominator format. These measures are derived from a variety of discovery activities and serve as both discovery and analytical tools. Data gathered from these discovery activities is compiled and trend-lines are developed by the

DA QA/QI Unit's QIS Program Director. This information is disseminated throughout the DA QA/QI Unit and is provided to FSSA and the QA/QI Committee for review and analysis. These entities assess the outcome of system design changes through comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in continuation of the quality improvement cycle.

Lessons learned from these activities will be communicated internally by the DA QA/QI Unit to the DA Waiver Unit and the DA Management Group, and externally to Case Management and provider entities at regional training and update meetings conducted by the DA for these groups.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

While the QIS is designed to identify opportunities for improvement in the service delivery system, the QIS itself must be monitored and improved upon. Improvements in the QIS will be necessary to keep up with changes in the regulatory and service delivery environments, and due to data or tools which the operators find to be inconsistent, incomplete or not conducive to obtaining desired measures or outcomes.

As the focal point for incoming data is the DA QA/QI Committee, this committee will have primary, but not exclusive, responsibility for analyzing QIS system performance. The committee will assess the reliability of the information presented to it by comparing the consistency of performance measurements across various perspectives. For example, results from incident reporting can be compared to health and safety data collected in the electronic case management database and results from the PCCT. Trend analysis may suggest more effective or more targeted performance measures, or reveal emerging risks which may not have been monitored previously.

As many of the data collection and analysis tools are electronic in nature, the committee will review opportunities to integrate new technology into the QIS. The committee will also actively seek input into QIS component performance from staff and contract entities who work with the various components on a day-to-day basis. Any complaints received from service recipients regarding QIS activities will be reviewed by the Committee. The QA/QI Committee will formally review the QIS at least annually, and make recommendations for changes or improvements to the DA Management Group.

The DA Management Group will assess the recommended changes and improvements and coordinate with internal advisory and regulatory groups such as Rules Committee or Technology Committee to evaluate and authorize potential changes. Once a change is approved, the DA Management Group will in most cases authorize the appropriate office to implement the approved changes, in coordination with the Waiver Work Group.

Modifications to the Quality Improvement Strategy will be submitted annually with the 372 report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under the provisions of the Single Audit Act, as amended by the Single Audit Act Amendments of 1996, the State utilizes the Indiana State Board of Accounts to conduct the independent audit of state agencies, including the Office of Medicaid Policy and Planning. FSSA routinely monitors audit resolution and provides annual status updates to SBOA.

The MMIS is used for claims payment submitted by approved waiver providers. The MMIS only reimburses waiver services that have been approved on an appropriate plan of care. Providers submit claims via the MMIS.

The electronic case management database system sends authorization for specific units of services to the claims payment system. The claims payment system pays only those claims that meet all authorization requirements. The Indiana Medicaid fiscal intermediary uses system edits and audits to make the appropriate reimbursement for services. When an audit shows a misuse of funds, the State recoups the money from the provider.

FSSA's Audit Unit is responsible for the annual review of services and billing performed by the AAA with full reporting to the OMPP and the Division of Aging.

PI has an agreement with the FSSA Audit Unit to audit allegations of HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit are part of FSSA Quality & Compliance so there is a natural level of collaboration and cooperation between the two Services. FSSA Audit's staff are knowledgeable of the different HCBS definitions, documentation standards, provider qualifications, and any required staffing ratios so it makes sense for them to audit allegations of wrongdoing in the waiver programs.

Process for Conducting Audits

PI receives allegations of provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their research and audit process. FSSA Audit works with PI to vet the providers with the Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation.

FSSA Audit may conduct statistically valid random sample of consumers and then Program Integrity's Fraud Abuse and Detection (FADS) vendor will pull a sample for their audit.

The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The random sample size is ultimately determined utilizing a tool developed by FADS contractors as well as their statistical consultants. The tool generates a statistically valid random sample size. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:

- Targeted Probe Audit Sample - A sample of sufficiently small size designed to focus on specific services, members, time frames or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues.
- Random Sample Audit - The goal of the random sample is to identify potential payment errors and extrapolate those errors to the entire universe of claims.

FSSA Audit conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with PI.

Audits are performed onsite utilizing a probe test that includes a review of:

- Providers' source documents. This include documents that support paid claims, e.g. employee signed service notes, logs, evidence of supervisory approvals.
- Payroll records. Dates/times/locations of service per claims are compared to related time cards and payroll registers.
- Employee background and qualifications. Supporting documents, found in human relations files, are reviewed. This includes documentation for background checks, licenses (if applicable), and search of the HHS/OIG exclusions list.

If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments. Valid statistical samples and sample results projections are provided by Program Integrity's FADS contractor.

FADS audits are initiated based on referrals received from different sources/agencies. The Surveillance and Utilization Review (SUR) Unit receives information from the following sources which could potentially lead to additional action including audit action:

1. IHCP Provider and Member Concerns Line;
2. Other agencies (MFCU);
3. Analyses/Analytics performed by the SUR Unit's Investigations team
4. Analytics performed by FADS contractors.

Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, the SUR Unit refers the provider(s) in question to FADS contractors for additional analysis which may include performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases with a special focus on any items identified as potential issues during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

- No further action – No issues uncovered warranting further action.
- Provider education – No major issues identified that would result in patient harm or recoveries to the program; however, it may be apparent that the provider as well as the Medicaid Program would benefit from the provider receiving additional

education on proper/best billing practices.

- Provider self audit – Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self-audit sample are evaluated by the contractor.
- Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.
- Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State program integrity personnel often also participate in on-site reviews.
- Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.
- * Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, Program Integrity is advised of any systemic issues identified. FSSA Audit Services seeks Program Integrity's advice on audit reporting and direction on technical questions.

For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action.

Analytics focusing on specific areas of concern are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit. A similar audit process as previously described would occur.

FADS contractors utilize federal and state guidelines as well as IHCP guidelines and national coding standards applicable to the date(s) of service being audited when determining whether services were billed appropriately. For medical review audits requiring clinician review, FADS contractors employ registered nurses and medical coders to also ensure all services were billed appropriately. When necessary, FADS contractors also rely on their Medical Directors and other medical consultants (e.g., dentists) to help confirm audit findings, including medical necessity, when appropriate.

The FADS contractor is continually creating and running analytics to identify aberrant billing patterns and potential overpayments. The FADS contractor's analytic team does audit based on allegation but often, these are not provider specific allegations. Instead the reviews conducted are targeted at a specific provider type or billing practice. This allows all providers billing that code set or included in that provider peer Services to be included in the analysis.

The FADS contractor runs annual provider profile reports comparing providers to their peers. These reports are run every quarter. These profiles compare generic measurements such as claims per day or dollars per claim. They allow all providers, regardless of whether they have been included in an allegation, to be measured and audited.

The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

On a more proactive level, FSSA Audit also routinely meets with each of the divisions that operate the waivers to identify and conduct audits on providers that have been identified as potentially not billing correctly.

On a more proactive level, FSSA Audit also routinely meets with DA to identify and conduct audits on providers that have been identified as potentially not billing correctly.

Detailed information on this policy can be found under the "SUR policy and procedures" available in the Medicaid Provider Manual Chapter 13: Utilization Review posted at: www.indianamedicaid.com.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I.1 Number and percent of claims paid appropriately according to the reimbursement methodology in the waiver application. Numerator: Number of claims paid appropriately according to the reimbursement methodology in the waiver application. Denominator: Number of claims submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

I.2 Number and percent of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Numerator: Number of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. **Denominator:** Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I.3 Number and percent of claims paid during the review period for services that are specified in the participant's approved service plan. Numerator: Number of claims paid during the review period due to services having been identified on the approved service plan. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance:** *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. Numerator: Total number of waiver rates that follow the approved methodology. Denominator: Total number of waiver rates

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

DA methodology and rate setting report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

--	--

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's service plan, are processed for reimbursement to providers who are enrolled Medicaid Aged & Disabled Waiver providers.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
I.1., I.2., and I.3. Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, the operating agency or OMPP staff.

For individual cases, the operating agency and/or the Medicaid Fiscal Contractor Provider Relations staff or SUR address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, OMPP or the operating agency will work with the Medicaid Fiscal Contractor and/or SUR to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, the OMPP Data Unit will extract pertinent claims data to verify the problem and determine correction needed. If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Assisted Living rates were established in 2007 using a state-wide fee-for-service rate. The Division of Aging reviews waiver rates bi-annually and will continue to collaborate with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding future rate changes. Assisted Living rates and the impact on recipient utilization for three State fiscal years are as follows:

	Level 1		Level 2		Level 3		Total Unduplicated Recipients				
	Rate	Recipient Count	% Inc	Rate	Recipient Count	% Inc	Rate	Recipient Count	% Inc	Rate	% Inc
SYF 2013	\$66.55	800		\$73.33	450		\$80.93	140		1,232	
SYF 2015	\$67.88	1,208	51%	\$74.80	707	57%	\$82.55	192	37%	1,905	55%
SFY 2016	\$67.88	1,520	26%	\$74.80	870	23%	\$82.55	219	14%	2,390	25%

From this data, the State observed that for SFY 2013 when Assisted Living rates were \$66.55, \$73.33 and \$80.93, the unduplicated recipient count was 1,232. Following a 2% rate increase effective 1/1/2014, the unduplicated recipient count increased to 1,905 by SFY 2015, and to 2,390 by SFY 2016.

In addition to increasing the number of recipients receiving Assisted Living services, the State also saw the number of Assisted Living providers grow over this period by one-third (1/3), which is believed to be directly related to the Medicaid waiver rate increases. The Number of Assisted Living providers increased as follows:

SFY 2013 68
SFY 2015 82
SFY 2016 91

The State also reviewed the number of counties in which Assisted Living services are provided. For the period from SFY 2013 to SFY 2016, the number of Indiana counties with Assisted Living providers increased from 35 to 41, out of 92 counties. Assisted Living providers are currently located in the most heavily populated counties, such that 70% of Indiana's population lives in a county where Assisted Living services are available.

With both the increasing number of recipients of Assisted Living services as well as the increasing number of Assisted Living providers, the State believes this demonstrates that increasing rates has helped to achieve the State's objective of expanding Assisted Living services as an alternative to nursing facility services. Additionally, with the increase in the number of counties where Assisted Living services are available, more Medicaid recipients now have access to this service. It should also be noted that Indiana has no wait list for Assisted Living waiver services.

A comparison to neighboring states indicates that Indiana's Assisted Living Medicaid waiver rates are slightly higher than Ohio. In Illinois, the Assisted Living rate of \$76.56 is used for about 98% of the Assisted Living recipients and is comparable to the average of Indiana's three rates.

Ohio – Assisted Living Waiver (7/1/2016 Assisted Living Rates)

Tier 1 \$49.48

Tier 2 \$60.00

Tier 3 \$69.98

Illinois – Supported Living Program Waiver (7/1/2016 Assisted Living Rates)

Assisted Living \$76.56

Assisted Living Capitated \$55.89

Since the increase in Assisted Living rates on 1/1/2014, the State now proposes to increase these rates by five percent (5%) effective June 30, 2017. The proposed rates for the three levels are as follows:

Level 1 \$71.71

Level 2 \$78.54

Level 3 \$86.68

Indiana is currently engaged in a 5 – 8 Year LTSS Rebalancing initiative with long term care stakeholders and providers. The goal of this initiative is to increase the utilization of home and community based services, and to decrease the reliance on institutional services relative to the growth in need for these services. Assisted Living services are currently available in 41 of Indiana's 92 counties. To achieve the objective of the 5 -8 Year Rebalancing initiative requires that the State now further expand Assisted Living services, both in the existing 41 counties as well as to the counties not currently being served. Based on past experience and provider feedback, increasing the reimbursement rates by 5% is a logical and reasonable step toward helping ensure that Indiana can achieve its policy objective of increasing the market and utilization for Assisted Living services under the waiver.

*****Previous language*****

The Division of Aging in collaboration reviewed the rate structure for all waivers including the Aged & Disabled waiver in FY 2007. The Division of Aging collaborated with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding the waiver rate reviews. Their valuable input into the waiver rate reviews is necessary to ensure that rates are sufficient to continue provider participation and participant access to waiver services.

Rates are set by establishing state-wide fee-for-service rates. There are rate differentials based upon whether the provider is an agency or non-agency (individual) provider. Non-agency provider's rates are less than agency rates based upon less administrative and general incurred expenses than agency provider rates.

The Division of Aging reviews waiver rates bi-annually. The Division of Aging will continue to collaborate on any revisions made to the Aged & Disabled waiver rates. The Division of Aging will continue to collaborate with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding future rate changes.

Notifications of any rate changes are posted to the Division of Aging's OPTIONS website and are available via the FSSA's Indiana Health Care Programs (IHCP): www.indianamedicaid.com. All other providers are notified of rate changes through banner pages; bulletins; and newsletters as prepared by the Division of Aging in collaboration with the FSSA distributed by the FSSA via the IHCP site.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If

billings flow through other intermediary entities, specify the entities:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal contractor.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ☒ **No. State or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Waiver service plan contains Medicaid reimbursable services that are available only under the Aged & Disabled (A&D) Waiver.

The Waiver Unit, within the operating agency, approves a participant's service plan within the State's case management database ensuring that only those services which are necessary and reimbursable under the Waiver. The service plan is sent to the state's fiscal agent, via systems interface with the MMIS, serving as the prior authorization for the participant's approved Waiver services. The case management system will not allow the addition of services beyond those services offered under the (A&D) Waiver. The case management data system has been programmed to alert the Waiver Unit when a service plan is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status

is in place, the service plan will be approved, and the system will generate the Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA identifies the individual participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data, on a daily cycle, containing all new or modified service plans to the Indiana MMIS. The service plan data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the Office of Medicaid Policy and Planning when executing Surveillance Utilization (SUR) activities. Additional information about these reviews can be found in chapter 13 of the Indiana Health Coverage Programs Provider Manual at the following link:

<http://provider.indianamedicaid.com/ihcp/manuals/chapter13.pdf>

In summary, the participant's eligibility for Medicaid Waiver services is controlled through the electronic case management system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

The State is currently in the design phase of a new integrated case management system which will mirror the functions previously described with added features and increased process automation. The implementation of the new system is slated for the summer of 2013.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- ☒ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS.

Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ☐ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

- f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

- i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

- ii. **Organized Health Care Delivery System.** *Select one:*

- ☒ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

- iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
☐ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are**

on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- ☐ **Applicable**
Check each that applies:
 - ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. **Services Furnished in Residential Settings.** *Select one:*

☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver. No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are

included in these fees.

Note: The waiver does not provide services in waiver group home settings. Participants are responsible for all room and board costs.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ☐ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:




Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- ☒ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:




Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10768.64	22025.84	32794.48	44389.37	3314.09	47703.46	14908.98
2	11818.19	23127.13	34945.32	45721.06	3479.79	49200.85	14255.53
3	10827.69	22278.78	33106.47	59892.95	3433.10	63326.05	30219.58
4	11382.63	21450.75	32833.38	62725.89	3245.47	65971.36	33137.98
5	12373.31	22308.78	34682.09	64607.67	3375.29	67982.96	33300.87

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	15265		15265
Year 2	16081		16081
Year 3	18778		18778
Year 4	21153		21153
Year 5	22519		22519

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

For this amendment, unduplicated participants projected to be served in Waiver Year (WY) 4 has been updated for this revision of the third amendment to increase slots by 2,000 from the prior amendment. It is further assumed that the number of slots for WY 5 will increase by 2,991.

Projections rely on actual enrollment data through the first six months of WY 4 (July 2016 through December 2016). For the last six months of WY 4 (January 2017 through June 2017), approximately 704 new enrollees are projected to enter the waiver each month. For WY 5, 500 new entrants are projected to enter each month for July 2017 - December 2017 and 450 new entrants are projected to enter each month for January 2018 - June 2018. Based on these assumptions the waiver will grow from 21,153 in WY 4 to 22,519 in WY 5.

Projected average length of stay has been updated to reflect actual experience during WY 1 – WY 3, and the first six months of WY 4. It has also been revised to reflect updated new entrant projections.

***** IN.004.05.02 *****

The average length of stay is calculated by verifying the total number of days all unduplicated participants are on the waiver divided by the number of unduplicated participants. Projected average length of stay has been updated to reflect actual experience during the first six months of WY 3 and updated new entrant projections.

Unduplicated participants projected to be served in Waiver Years (WY) 3-5 has been updated for the second amendment to project new entrants as follows: 487 per month for the remainder of WY 3, 330 per months for the WY 4 and 365 new entrants per month for WY 5. Please note the following assumptions:

- no reliance on approval of additional MFP slots for the Money Follows the person demonstration grant;
- no waitlist-waiver enrollment is to remain open.

Projections rely on actual enrollment data through the first six months of WY 3 (July 2015-December 2015).

WY 3 Slots are now 18,778

WY 4 Slots are now 19,153

WY 5 Slots are now 19,528 based on the aforementioned assumptions.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For the current amendment, Base Year data reflects experience from Waiver Year 3 of the current renewal: July 1, 2015 – June 30, 2016. The base year data was adjusted for waiver years 4 through 5 in the following manner:

- o Number of users of each service was adjusted based on projected slots.
- o Average unites per user were projected to vary with average length of stay.
- o Average cost per unit is inflated at an annual rate of 2% per year.
- o Assisted Living reimbursement is increased by 5% effective June 30, 2017.
- o Utilization for the Assisted Living services has been increasing each year. Since utilization has continued to increase, the projected number of the unique users for this service has been increased by approximately 15% for WY 4.

Estimates for Factor D for each waiver year are illustrated in the cost neutrality summary in the table in J-1.

***** IN.004.05.02 *****

Base Year data reflects actual experience from Waiver Year 2 of the current renewal: July 1, 2014 - June 30, 2015. The base year date was adjusted for waiver years 3 to 5 in the following manner:

- Number of users of each service was adjusted based on projected slots.
- Average units per user were projected to vary with average length of stay.
- Average cost per unit is inflated at an annual rate of 2% per year.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver year 3 of the current renewal: July 1, 2015 – June 30, 2016. Base year data was trended at 4.0% per year.

Estimates for Factor D' for each waiver year are illustrated in the cost neutrality summary table in J-1.

***** IN.004.05.02 *****

Base Year data reflects actual experience from Waiver Year 2 of the current renewal: July 1, 2014 - June 30, 2015. Factor D' includes all State Plan services received by A&D waiver recipients while enrolled on the waiver. Base year data was trended at 4.0% per year.

The derivation of Factor D' does not include the cost of prescribed drugs furnished to Dual Eligibles under the

provision of Medicare Part D. All the base data used for this waiver renewal was from time periods after the implementation of Part D, so those costs are not in the claims data.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 3 of the current renewal: July 1, 2015 – June 30, 2016. Base Year data was inflated forward at 3.0% per year. Factor G for WY 3 also includes \$893.6 million in Nursing Facility Upper Payment limit expenditures, contributing \$24,819 to the value of Factor G in WY 3. Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary table in J-1.

***** IN.004.05.02 *****

Base Year data reflects actual experience from Waiver Year 2 of the current renewal: July 1, 2014-June 30, 2015. Base year data was inflated forward at 3.0% per year. In addition, \$828.2 million in Nursing Facility Upper Payment limit expenditures paid in WY2 was also included in Factor G for the Base Year, contributing \$22,907 to the value of Factor G in the waiver year 2.

Total reimbursement provided to Nursing Facilities includes both claims-based and non claims-based payments. The claims-based payments include reimbursement at Medicaid per diems rates. Federal regulations allow for federal matching funds to also support supplemental payments that effectively increase reimbursement up to the amount that Medicare would have paid for comparable services from the Nursing facilities.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from WY 3 of the current renewal: July 1, 2015 – June 30, 2016. Base Year data was trended at 4.0% per year. Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary table in J-1.

***** IN.004.05.02 *****

Base Year data reflects actual experience from Waiver Year 2 of the prior renewal: July 1, 2014 - June 30, 2015. Base year data was trended at 4.0% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Service
Attendant Care
Case Management
Homemaker
Respite
Adult Family Care
Assisted Living
Community Transition
Environmental Modification Assessment
Environmental Modifications
Health Care Coordination
Home Delivered Meals
Nutritional Supplements
Personal Emergency Response System

Pest Control
Specialized Medical Equipment and Supplies
Structured Family Caregiving
Transportation
Vehicle Modifications

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						4501680.75
Adult Day Service	1/4 Hour	575	2601.00	3.01	4501680.75	
Attendant Care Total:						71322145.44
Attendant Care	1/4 Hour	7784	2073.00	4.42	71322145.44	
Case Management Total:						14710000.00
Case Management	Monthly	14710	10.00	100.00	14710000.00	
Homemaker Total:						11182617.60
Homemaker	1/4 Hour	4697	640.00	3.72	11182617.60	
Respite Total:						22907433.00
Respite	1/4 Hour	2972	1195.00	6.45	22907433.00	
Adult Family Care Total:						1238462.94
Adult Family Care	Day	71	247.00	70.62	1238462.94	
Assisted Living Total:						22410462.84
Assisted Living	Day	1451	226.00	68.34	22410462.84	
Community Transition Total:						1906.98
Community Transition	Unit	2	1.00	953.49	1906.98	
Environmental Modification Assessment Total:						376500.00
Environmental Modification Assessment	Unit	753	1.00	500.00	376500.00	
Environmental Modifications Total:						2403308.80
Environmental Modifications	Unit	685	1.00	3508.48	2403308.80	

Health Care Coordination Total:						11419.36
Health Care Coordination RN Service	1/4 Hour	8	149.00	9.58	11419.36	
Home Delivered Meals Total:						8382223.92
Home Delivered Meals	Meal	6107	258.00	5.32	8382223.92	
Nutritional Supplements Total:						30959.50
Nutritional Supplements	Unit	55	130.00	4.33	30959.50	
Personal Emergency Response System Total:						2521696.80
Personal Emergency Response System	Unit	7322	10.00	34.44	2521696.80	
Pest Control Total:						89730.06
Pest Control	Unit	278	3.00	107.59	89730.06	
Specialized Medical Equipment and Supplies Total:						370849.05
Specialized Medical Equipment and Supplies	Unit	459	1.00	807.95	370849.05	
Structured Family Caregiving Total:						348862.80
Structured Family Caregiving	Day	20	247.00	70.62	348862.80	
Transportation Total:						1394285.76
Transportation	Trip	414	194.00	17.36	1394285.76	
Vehicle Modifications Total:						178671.36
Vehicle Modifications	Unit	56	1.00	3190.56	178671.36	
GRAND TOTAL:						164383216.96
Total Estimated Unduplicated Participants:						15265
Factor D (Divide total by number of participants):						10768.64
Average Length of Stay on the Waiver:						279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						5247013.75
Adult Day Service	1/4 Hour	605	2825.00	3.07	5247013.75	
Attendant Care Total:						

						83283464.00
Attendant Care	1/4 Hour	8200	2252.00	4.51	83283464.00	
Case Management Total:						15496000.00
Case Management	Monthly	15496	10.00	100.00	15496000.00	
Homemaker Total:						13033279.40
Homemaker	1/4 Hour	4948	695.00	3.79	13033279.40	
Respite Total:						26741370.04
Respite	1/4 Hour	3131	1298.00	6.58	26741370.04	
Adult Family Care Total:						1447803.00
Adult Family Care	Day	75	268.00	72.03	1447803.00	
Assisted Living Total:						26109968.50
Assisted Living	Day	1529	245.00	69.70	26109968.50	
Community Transition Total:						2917.68
Community Transition	Unit	3	1.00	972.56	2917.68	
Environmental Modification Assessment Total:						397000.00
Environmental Modification Assessment	Unit	794	1.00	500.00	397000.00	
Environmental Modifications Total:						2580206.65
Environmental Modifications	Unit	721	1.00	3578.65	2580206.65	
Health Care Coordination Total:						14244.66
Health Care Coordination RN Service	1/4 Hour	9	162.00	9.77	14244.66	
Home Delivered Meals Total:						9782253.60
Home Delivered Meals	Meal	6434	280.00	5.43	9782253.60	
Nutritional Supplements Total:						36146.76
Nutritional Supplements	Unit	58	141.00	4.42	36146.76	
Personal Emergency Response System Total:						2980921.02
Personal Emergency Response System	Unit	7714	11.00	35.13	2980921.02	
Pest Control Total:						96461.46
Pest Control	Unit	293	3.00	109.74	96461.46	
Specialized Medical Equipment and Supplies Total:						398869.24
Specialized Medical Equipment and Supplies	Unit	484	1.00	824.11	398869.24	
Structured Family Caregiving Total:						579121.20
Structured Family Caregiving	Day	30	268.00	72.03	579121.20	

Transportation Total:						1629249.16
Transportation	trip	436	211.00	17.71	1629249.16	
Vehicle Modifications Total:						192007.83
Vehicle Modifications	Unit	59	1.00	3254.37	192007.83	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						190048297.95 16081 11818.19 303

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						5568744.23
Adult Day Service	1/4 Hour	697	2569.00	3.11	5568744.23	
Attendant Care Total:						80682926.94
Attendant Care	1/4 Hour	9917	1761.00	4.62	80682926.94	
Case Management Total:						16431489.90
Case Management	Monthly	18270	9.00	99.93	16431489.90	
Homemaker Total:						12624817.51
Homemaker	1/4 Hour	5503	599.00	3.83	12624817.51	
Respite Total:						24683758.50
Respite	1/4 Hour	3270	1115.00	6.77	24683758.50	
Adult Family Care Total:						1190536.10
Adult Family Care	Day	65	254.00	72.11	1190536.10	
Assisted Living Total:						36362853.45
Assisted Living	Day	2205	231.00	71.39	36362853.45	
Community Transition Total:						7247.92
Community Transition	Unit	8	1.00	905.99	7247.92	
Environmental Modification						

Assessment Total:						87001.20
Environmental Modification Assessment	Unit	312	1.00	278.85	87001.20	
Environmental Modifications Total:						3022652.02
Environmental Modifications	Unit	697	1.00	4336.66	3022652.02	
Health Care Coordination Total:						23002.20
Health Care Coordination RN Service	1/4 Hour	20	117.00	9.83	23002.20	
Home Delivered Meals Total:						12265792.00
Home Delivered Meals	Meal	8384	266.00	5.50	12265792.00	
Nutritional Supplements Total:						52823.58
Nutritional Supplements	Unit	109	123.00	3.94	52823.58	
Personal Emergency Response System Total:						3502067.40
Personal Emergency Response System	Unit	9399	10.00	37.26	3502067.40	
Pest Control Total:						142190.10
Pest Control	Unit	390	3.00	121.53	142190.10	
Specialized Medical Equipment and Supplies Total:						590471.64
Specialized Medical Equipment and Supplies	Unit	759	2.00	388.98	590471.64	
Structured Family Caregiving Total:						4025322.54
Structured Family Caregiving	Day	353	162.00	70.39	4025322.54	
Transportation Total:						1863470.60
Transportation	Trip	538	190.00	18.23	1863470.60	
Vehicle Modifications Total:						195272.00
Vehicle Modifications	Unit	44	1.00	4438.00	195272.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						203322439.83 18778 10827.69 272

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						6170351.96
Adult Day Service	1/4 Hour	716	2771.00	3.11	6170351.96	
Attendant Care Total:						85879282.24
Attendant Care	1/4 Hour	10742	1723.00	4.64	85879282.24	
Case Management Total:						18657362.16
Case Management	Monthly	20747	9.00	99.92	18657362.16	
Homemaker Total:						12803552.12
Homemaker	1/4 Hour	5609	596.00	3.83	12803552.12	
Respite Total:						24642012.90
Respite	1/4 Hour	3370	1093.00	6.69	24642012.90	
Adult Family Care Total:						1267893.90
Adult Family Care	Day	63	274.00	73.45	1267893.90	
Assisted Living Total:						54189187.00
Assisted Living	Day	3260	239.00	69.55	54189187.00	
Community Transition Total:						30384.20
Community Transition	Unit	35	1.00	868.12	30384.20	
Environmental Modification Assessment Total:						78145.04
Environmental Modification Assessment	Unit	292	1.00	267.62	78145.04	
Environmental Modifications Total:						4713454.44
Environmental Modifications	Unit	789	2.00	2986.98	4713454.44	
Health Care Coordination Total:						21475.08
Health Care Coordination RN Service	1/4 Hour	22	99.00	9.86	21475.08	
Home Delivered Meals Total:						13766395.68
Home Delivered Meals	Meal	9004	279.00	5.48	13766395.68	
Nutritional Supplements Total:						80383.16
Nutritional Supplements	Unit	169	94.00	5.06	80383.16	
Personal Emergency Response System Total:						3947013.00
Personal Emergency Response System	Unit	10105	10.00	39.06	3947013.00	
Pest Control Total:						201378.96
Pest Control	Unit	486	3.00	138.12	201378.96	
Specialized Medical Equipment and Supplies Total:						740274.56

Specialized Medical Equipment and Supplies	Unit	916	2.00	404.08	740274.56	
Structured Family Caregiving Total:						11355301.98
Structured Family Caregiving	Day	809	198.00	70.89	11355301.98	
Transportation Total:						2001654.00
Transportation	Trip	549	200.00	18.23	2001654.00	
Vehicle Modifications Total:						231247.98
Vehicle Modifications	Unit	43	1.00	5377.86	231247.98	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						240776750.36 21153 11382.63 271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						7087194.36
Adult Day Service	1/4 Hour	762	2934.00	3.17	7087194.36	
Attendant Care Total:						98709778.75
Attendant Care	1/4 Hour	11435	1825.00	4.73	98709778.75	
Case Management Total:						22069330.40
Case Management	Monthly	22087	10.00	99.92	22069330.40	
Homemaker Total:						14694033.90
Homemaker	1/4 Hour	5971	631.00	3.90	14694033.90	
Respite Total:						28377994.32
Respite	1/4 Hour	3588	1158.00	6.83	28377994.32	
Adult Family Care Total:						1455695.60
Adult Family Care	Day	67	290.00	74.92	1455695.60	
Assisted Living Total:						64104988.20
Assisted Living					64104988.20	

	Day	3470	253.00	73.02		
Community Transition Total:						33648.24
Community Transition	Unit	38	1.00	885.48	33648.24	
Environmental Modification Assessment Total:						84893.67
Environmental Modification Assessment	Unit	311	1.00	272.97	84893.67	
Environmental Modifications Total:						5118489.60
Environmental Modifications	Unit	840	2.00	3046.72	5118489.60	
Health Care Coordination Total:						25351.20
Health Care Coordination RN Service	1/4 Hour	24	105.00	10.06	25351.20	
Home Delivered Meals Total:						15859724.40
Home Delivered Meals	Meal	9585	296.00	5.59	15859724.40	
Nutritional Supplements Total:						92880.00
Nutritional Supplements	Unit	180	100.00	5.16	92880.00	
Personal Emergency Response System Total:						4285987.20
Personal Emergency Response System	Unit	10758	10.00	39.84	4285987.20	
Pest Control Total:						218927.52
Pest Control	Unit	518	3.00	140.88	218927.52	
Specialized Medical Equipment and Supplies Total:						803712.00
Specialized Medical Equipment and Supplies	Unit	975	2.00	412.16	803712.00	
Structured Family Caregiving Total:						13074371.10
Structured Family Caregiving	Day	861	210.00	72.31	13074371.10	
Transportation Total:						2290734.16
Transportation	Trip	584	211.00	18.59	2290734.16	
Vehicle Modifications Total:						246843.90
Vehicle Modifications	Unit	45	1.00	5485.42	246843.90	
GRAND TOTAL:						278634578.52
Total Estimated Unduplicated Participants:						22519
Factor D (Divide total by number of participants):						12373.31
Average Length of Stay on the Waiver:						287